

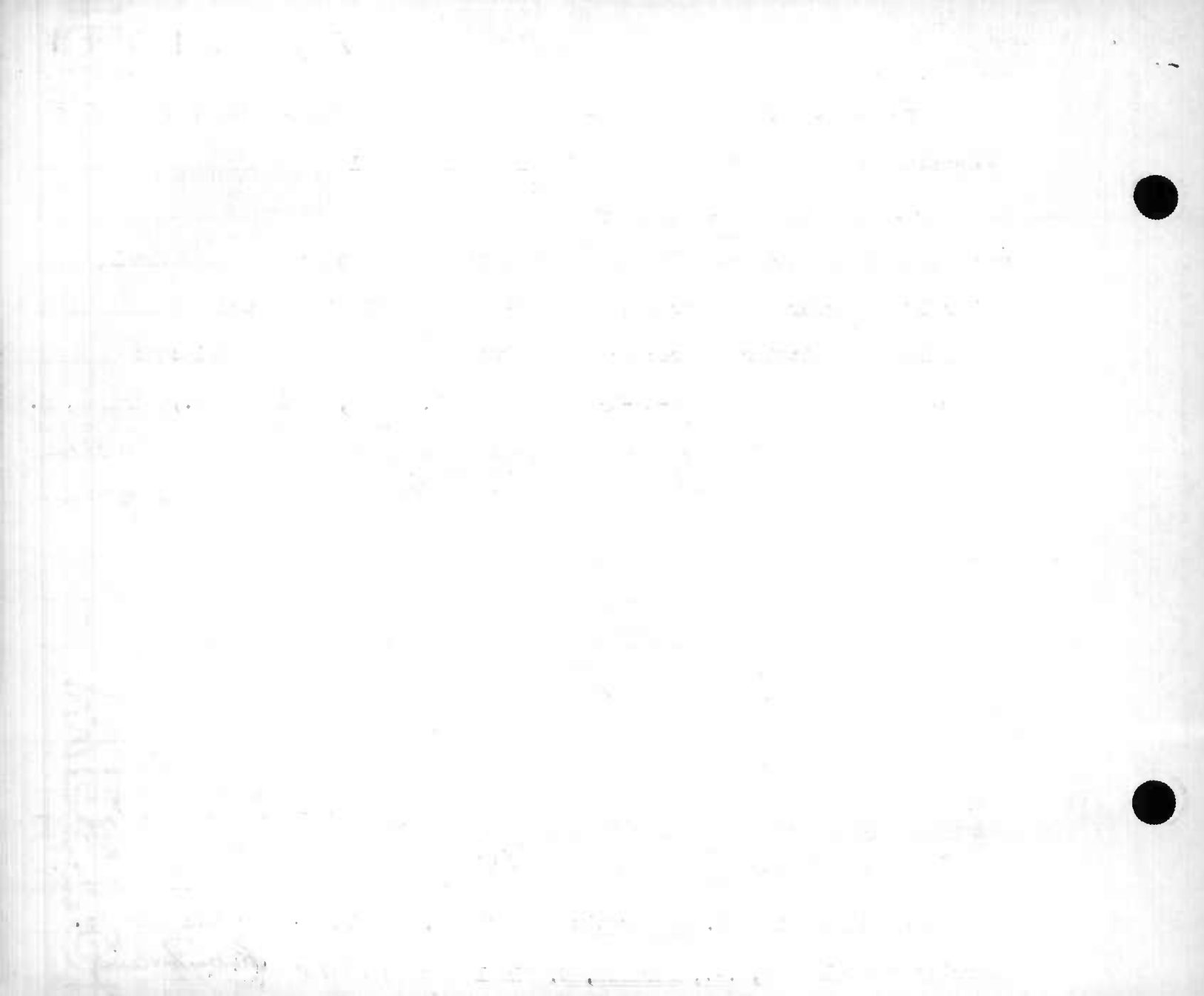
TO HOSPITAL CERTIFYING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 0 4 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Brenda Crocker Adams				2a. DATE OF DEATH MONTH DAY YEAR Dec. 12 1979			
3 SEX Female				2b. HOUR 5 ¹⁰ PM			
4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1978		6 AGE (IN YEARS LAST BIRTHDAY) 67 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Vermont		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD	
10 CITY OR TOWN OF DEATH Harve de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher		12b. KIND OF BUSINESS OR INDUSTRY School	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Rowland Whittier Crocker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva Whitcomb			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 008-10-1340		17. INFORMANT ADDRESS Channing L. Adams, 29 Rigdon Rd., Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 1a: Massive Brain Stem Pontine hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b): H. + A. S. C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c): CONDITIONS, if any, which gave rise to immediate cause 1a, stating the underlying cause last: 4029						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/6 19 79 to 12/12 19 79 , that (I) (we) last saw the deceased alive on 12/12 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE Edward C. Loo, M.D. DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. Loo, M.D.				22e. ADDRESS Harve de Grace, Md. 21078			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 13 Dec. 79		23c. NAME OF CEMETERY OR CREMATORY Cratin & Ferris		23d. LOCATION CITY OR TOWN COUNTY STATE West Chester Chester Pa.	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001				25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE Patricia Melody	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 0 4 2

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Anna Jelinek Anderle			2a. DATE OF DEATH MONTH DAY YEAR 12 22 79			2b. HOUR 2:45 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 15 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? Czechoslovakia		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Citizens Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.					13b. COUNTY Harford		13c. CITY OR TOWN Belcamp		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Jelinek					15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ana Zdarska Jelinek					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown No		16b. SOCIAL SECURITY NO. 213-60-0642		17. INFORMANT Anna Ulehla		17. ADDRESS 201 Crocker Dr. Bel Air, Md. 21014				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) CARCINOMATOSIS (c) CARCINOMA OF LUNGS 6 mos								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 6 mos 6 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4/19, 1979, to 12/21, 1979, that (I) (we) last saw the deceased alive on 12/21, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
23. SIGNATURE Dante Monakil					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/22/79			
23a. PHYSICIAN'S NAME (TYPE OR PRINT) DANTE MONAKIL					22b. ADDRESS 672 Gilman Ave North Laurel, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 12/24/1979		23c. NAME OF CEMETERY OR CREMATORY Green Mount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md.					25a. DATE REC'D. BY REGISTRAR DEC 28 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4 should be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 4 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Mariam Rosetta Andrews										2a. DATE OF DEATH MONTH 12 DAY 20 YEAR 79				2b. HOUR 5:55 P.M.	
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH Sept DAY 27 YEAR 1910			6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS 		8. IF UNDER 24 HRS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD								
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hartford Memorial Hosp			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY LA MC							
13a. STATE Md.				13b. COUNTY Cecil		13c. CITY OR TOWN Port Deposit		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 18 Brenda St.					
14. FATHER'S NAME FIRST Christopher MIDDLE C LAST Frassington				15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST Hughes											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 162-24-1273		17. INFORMANT JAMES C. Andrews, Penquill, Mary Had									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Hypertension 1521 DUE TO, OR AS A CONSEQUENCE OF Senile of Pertinence DUE TO, OR AS A CONSEQUENCE OF Perforated Malig. nodule jejunum PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 2 wk 2 wk					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 11-29 , 19 79 , to 12-20 , 19 79 , that (I) (we) last saw the deceased alive on 12-20 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.															
22b. SIGNATURE William K. Brundle				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-20-79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William K. Brundle M.D.				22e. ADDRESS South Union Ave, Havre de Grace Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec 23, 1979		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery			23d. LOCATION CITY OR TOWN Port Deposit, Cecil, Maryland COUNTY STATE 21078								
24. FUNERAL DIRECTOR Lee A. Patterson & Son, Inc.				ADDRESS erryville, Maryland				25a. DATE REC'D BY REGISTRAR DEC 28 1979							
				25b. REGISTRAR'S SIGNATURE 											

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(VRA 15, 4) 7/78



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			79 31044 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Mary Katherine Bauer						12-18-79			6:58 AM
3 SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
F	W	9 10 19		60 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.		USA				Harford. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hosp.							
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Md.			Har		Bel Air		#2 North Atwood Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
			215-14-7908						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of the Rectum</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 months</u>	
1541 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>With intraabdominal metastasis</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>With Anemia</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Inanition / Cachexia</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>79</u> , to <u>Dec 17</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>Dec 17</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
<u>Perfecto Valerao</u>								12-18-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
PERFECTO VALARAO MD.			1716 Harford Road Fallston Md 21047						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Removal			12/18/79						
24. FUNERAL DIRECTOR NAME					ADDRESS		25a. DATE REC'D. BY REGISTRAR		
Anatomy Board					Balto., Md.		DEC 24 1979		
					25b. REGISTRAR'S SIGNATURE				
					<u>Christy McElroy</u>				



THE
HUMANITIES
COUNCIL
ON
EDUCATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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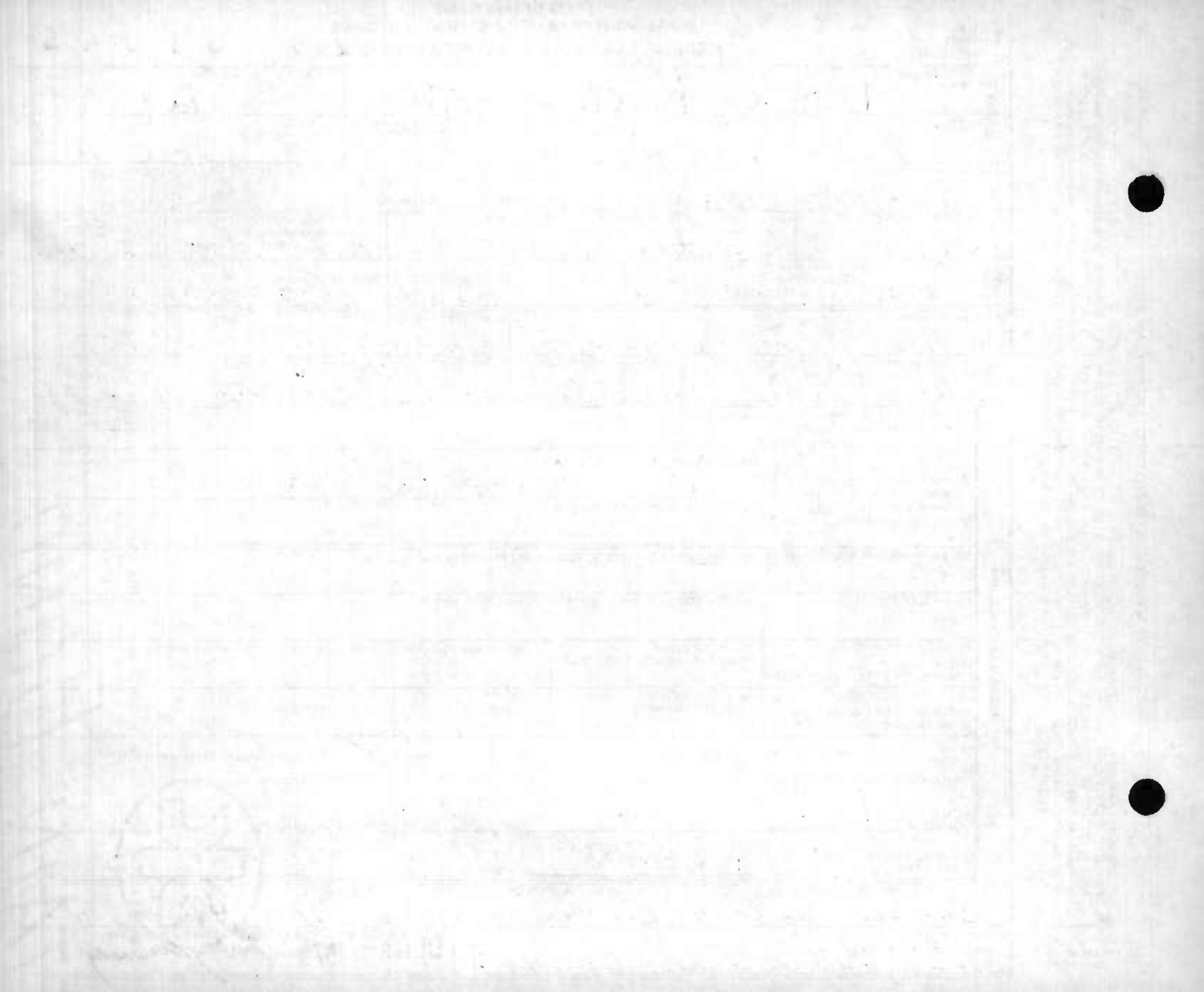
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 9

REG. NO. 31045

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST Denise		MIDDLE Annette		LAST Benedetto		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 12		DAY 1		YEAR 1979		2b. HOUR 9:30 A.M.			
3. SEX F		4. RACE Cauc		5. DATE OF BIRTH MONTH 8		DAY 15		YEAR 58		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS		7c. DATE PRONOUNCED DEAD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford MD.													
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Social Security		12b. KIND OF BUSINESS OR INDUSTRY Civil Service					
13a. STATE Md		13b. COUNTY Hartford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 623 Derringer Drive											
14. FATHER'S NAME FIRST William				MIDDLE A				LAST Benedetto				15. MOTHER'S MAIDEN NAME FIRST Candida				MIDDLE Riutort			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES) NONE				16b. SOCIAL SECURITY NO. 218-72-6751				17. INFORMANT (FATHER) MR Wm. A Benedetto				ADDRESS Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 2429 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which } gave rise to immediate } cause (a) stating the under- } lying cause last. } (b) <u>Probable Hyperthyroidism</u> DUE TO, OR AS A CONSEQUENCE OF } (c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Willard P Amoss				TITLE (SPECIFY) M.D. Asst Dep				MEDICAL EXAMINER				DATE SIGNED 12/1/79							
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss				ADDRESS 2404 Plesantville Rd Fallston MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12-5-79				23c. NAME OF CEMETERY OR CREMATORY BEL MEMORIAL GARDENS				23d. LOCATION CITY OR TOWN COUNTY STATE BEL AIR HARTFORD MD							
24. FUNERAL DIRECTOR NAME E. BARNES				ADDRESS Fleming Funeral Service				25a. DATE REC'D. BY REGISTRAR DEC 3 1979				25b. REGISTRAR'S SIGNATURE Anthony McBrady							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31046

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2c. DATE PRONOUNCED DEAD		2d. HOUR	
George M. Bertholdt, Sr.		12 22 1979		3 45 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.
M	Cauc	10 13 21 58	58 YRS.	MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Baltimore, Md.		USA		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Fallston		Fallston General Hospital		Mechanical Maintenance	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
Md		Harford		Edgewood	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.	
Milton Bertholdt		Mildred ?		220 01 5019	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17c. INFORMANT	
Yes		WWII		Mildred Bertholdt, Wife	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. DATE OF OPERATION		20. AUTOPSY?	
PART I DEATH WAS CAUSED BY:		19a. DATE OF OPERATION		YES <input type="checkbox"/> NO <input type="checkbox"/>	
IMMEDIATE CAUSE (a)		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			
410 - Cardiac Arrest					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY	
Massive Myocardial Infarction		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED	
Arteriosclerotic Heart Disease		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		21g. CITY OR TOWN		21h. COUNTY	
		21i. STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Burial		12/26/79		23c. NAME OF CEMETERY OR CREMATORY	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Bruzdzinski Funeral Home		Gardens of Faith Cemetery		23f. REGISTRAR'S SIGNATURE	
PA 1407 Old Eastern Ave		Baltimore Co., Md.		DEC 28 1979	

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

79 31047

1 - FOR STATE REGISTRAR (Myrtle Adelaide Blair)

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST myrtle Adelaide Blair			2a. DATE OF DEATH MONTH DAY YEAR 12 11 79		2b. HOUR 7:15AM
3 SEX Female	4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR 1 15 20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland New York	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.	
10. CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE New York	13b. COUNTY Franklin Co.	13c. CITY OR TOWN North Bangor	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS Gallup Road	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Brooks		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Dean			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) —		17. INFORMANT (Husband) 1-518-358-2815 R.F.D. Mr. Edwin G. Blair Bombay, New York 12914	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Severe Malnutrition - Electrolyte imbalance</u> <u>179-</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extensive Metastatic Ca</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Primary uterine Cancer</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 wk</u> <u>1 yr</u> <u>2 yrs</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d): <u>None</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>11-15-1979</u> to <u>12-11-1979</u> , that (I) (we) last saw the deceased alive on <u>12-11-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.					
22b. SIGNATURE <u>M.D.</u>		DEGREE		22c. DATE SIGNED 12-11-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR M.D.		22e. ADDRESS 200 MILTON AVE, FALLSTON, MD 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 14, 1979		23c. NAME OF CEMETERY OR CREMATORY St. Augustine Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE North Bangor, Franklin Co., New York		24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams Sts Baltimore, Maryland 21014		25a. DATE REC'D. BY REGISTRAR DEC 12 1979	
25b. REGISTRAR'S SIGNATURE Kristy McBrady					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 7 9 3 1 0 4 8			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Minnie Ada Bolt										2a. DATE OF DEATH MONTH DAY YEAR Dec. 14, 1979		2b. HOUR 1:08 P.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 02 09 91		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 74 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY --					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Harford Joppa										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 815 Magnolia Road	
14. FATHER'S NAME FIRST MIDDLE LAST Pleasant Amos McPeak				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Day									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 215-76-8325		17. INFORMANT ADDRESS Mrs. Elaine Bellmyer, Joppa, Md.							
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Mesenteric Ischemic Bowel Disease</u> 5570 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Acidosis</u>													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Leticia S. Galvez, M.D.</u>				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/15/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ, M.D.				22e. ADDRESS 622 S. UNION AVE H'd Grace Md. 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec. 17, 1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <u>Leticia S. Galvez</u>					

BP

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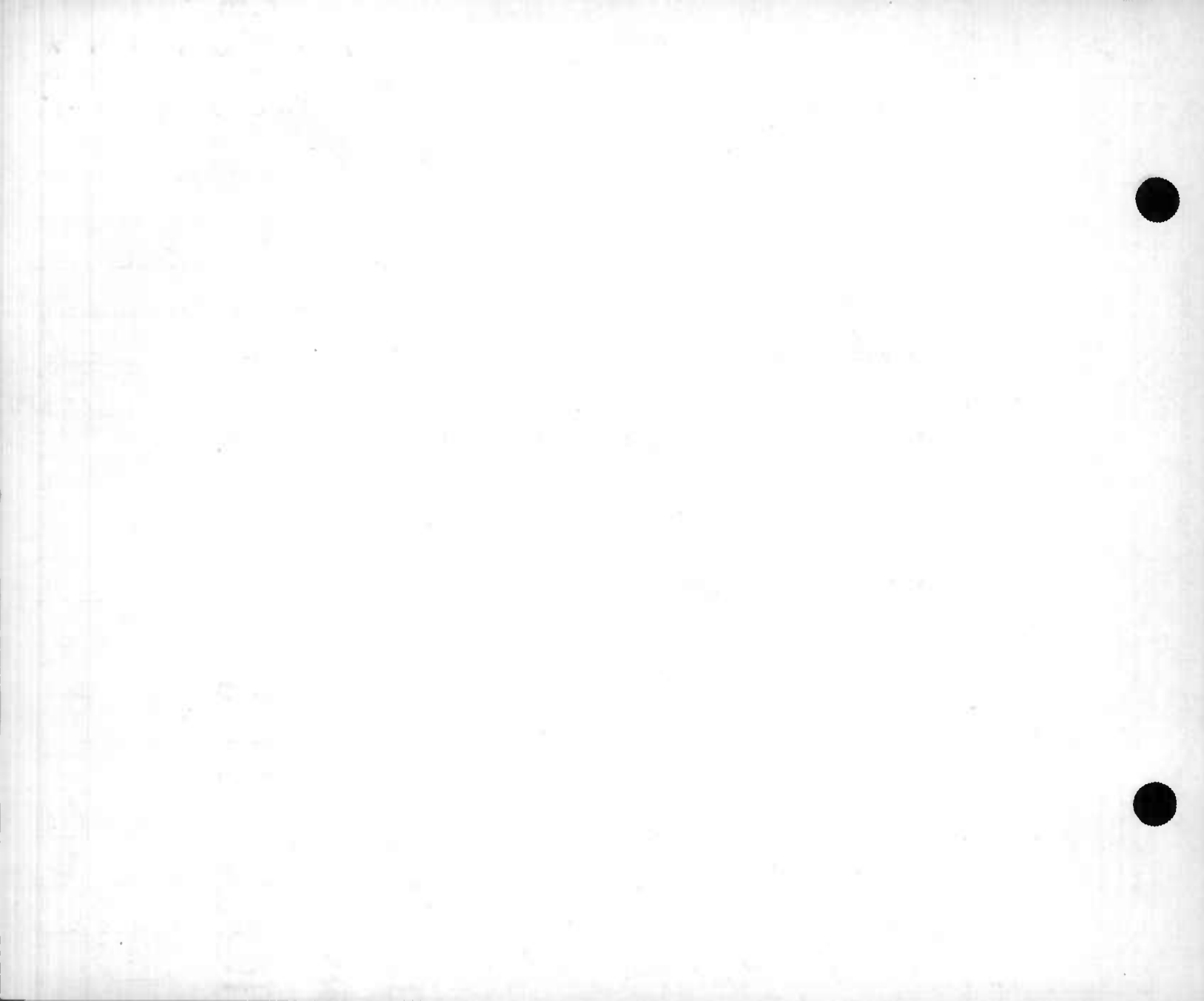
11/11/11 11:11

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 4 9 REG. NO.			
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frank Louis Bosze						2a. DATE OF DEATH MONTH DAY YEAR Dec. 6 1979			2b. HOUR 9:41 P		
3 SEX male		4 RACE white		5 DATE OF BIRTH MONTH DAY YEAR Nov. 18 1915		6 AGE (IN YEARS LAST BIRTHDAY) YRS 63		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA			
7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7d. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10 CITY OR TOWN OF DEATH Harre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY SAME					
13a. STATE MD		13b. COUNTY Harford		13c. CITY OR TOWN Harre de Grace		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 253 Wilson St.					
14 FATHER'S NAME FIRST MIDDLE LAST Unknown		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO							
16b. SOCIAL SECURITY NO 291-18-3223		17 INFORMANT Orhelda Bosze				ADDRESS 253 Wilson St. Harre de Grace, MD							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest & Ventricular Fibrillation 4029 DUE TO, OR AS A CONSEQUENCE OF (b) Sudden Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) H.A.S.C.V.D. 2-3 years.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Congestive Heart Failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, PARK, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 12/6 1979 to 12/6 1979 , that (I) (we) last saw the deceased alive on 12/6 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Edward C. Loo		DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.		22e. ADDRESS Harre de Grace, Md.				22f. DATE REC'D BY REGISTRAR DEC 11 1979							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12/10/1979		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE HARREDEGRACE, HARFORD, MD							
24 FUNERAL DIRECTOR NAME Pennington Hw, Harre de Grace, Md.		24b. ADDRESS Harre de Grace, Md.				25a. DATE REC'D BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE Harold C. Loo					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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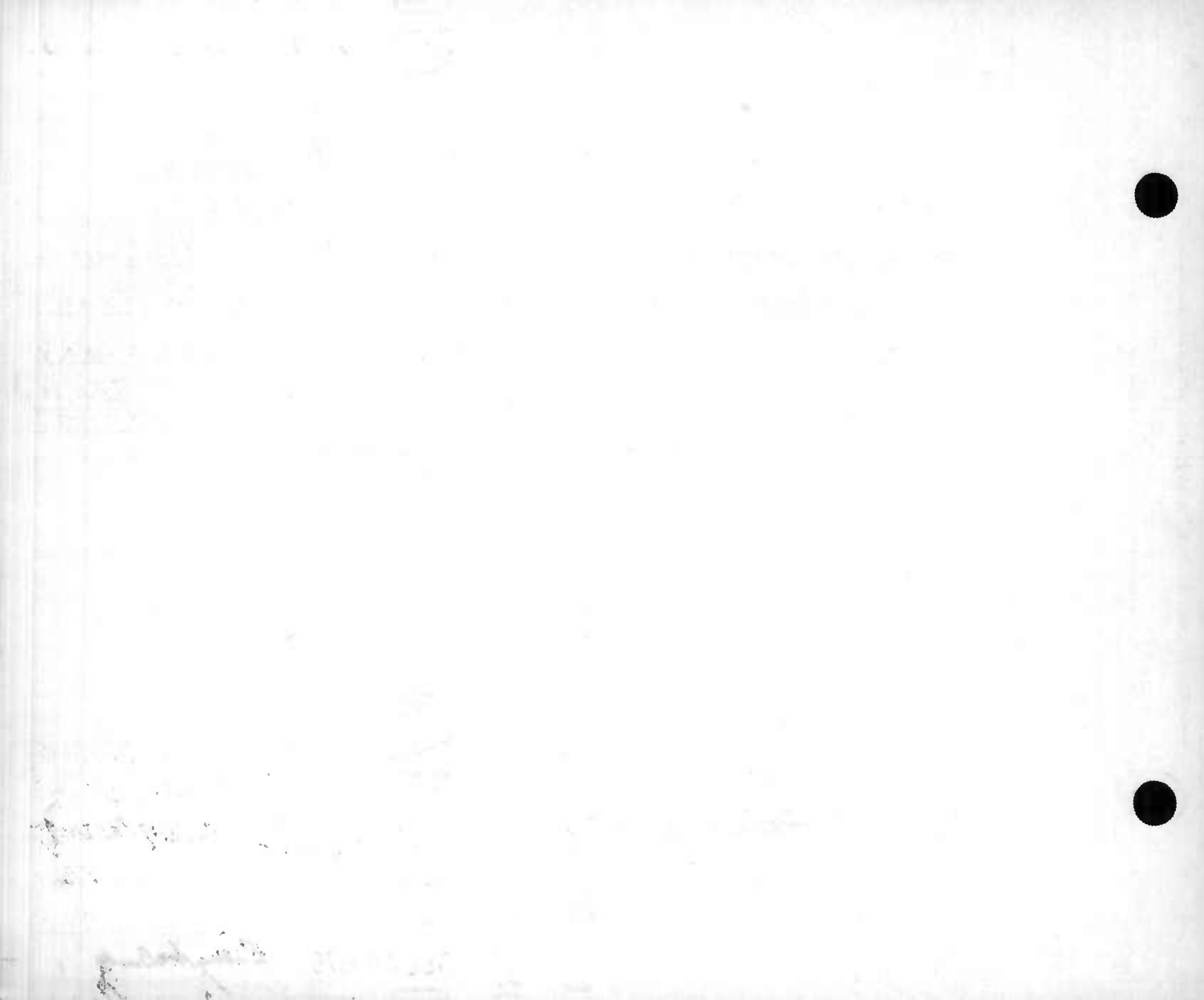
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1

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 0 5 0 REG. NO.		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST		MIDDLE		LAST		MONTH		DAY	
Isabell				BRAXTON		Dec. 18		79	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		Black		JAN. 27, 1925		54		MONTHS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. IF UNDER 72 HRS	
MD.		USA				HARFORD		HOURS	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. IF UNDER 24 HRS	
HARFORD		Harford Memorial Hosp.		Cook		Organ Ind. Co.		MIN.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
MD		Harford		DARLINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		RT 2 RIVER ROAD	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
THOMAS		KIZIAH		NO		220-24-3759		James L. Braxton - Darlington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 410 - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Arteriosclerotic Cardiovascular disease</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>4/20</u> , 19 <u>79</u> , to <u>12/15</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>George T. Stansbury, M.D.</u> 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George T. Stansbury, M.D.</u>		22c. DATE SIGNED <u>12/15/79</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Dec. 21, 1979</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Harford Harford Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Chas J. Bullock, Harford, Md.</u>		25. DATE REC'D. BY REGISTRAR		25a. REGISTRAR'S SIGNATURE <u>Harry H. H. H.</u>					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M/7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31051

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST CECIL			MIDDLE HOWARD			LAST BURNETT			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 12			DAY 20			YEAR 1979			2b. HOUR 4:30												
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH 7			DAY 4			YEAR 25			6. AGE (IN YEARS) LAST BIRTHDAY 54 YRS.			IF UNDER 1 YR. MONTHS			IF UNDER 24 HRS. DAYS			7c. DATE PRONOUNCED DEAD			MONTH 12			DAY 20			YEAR 1979			2d. HOUR 4:50		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED WIDOWED				<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED				9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.																				
10. CITY OR TOWN OF DEATH HARFORD				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber				12b. KIND OF BUSINESS OR INDUSTRY Constr.																
13a. STATE MD				13b. COUNTY HARFORD				13c. CITY OR TOWN ABERDEEN				14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13a. STREET ADDRESS 143 EAST DEAN, ABERDEEN																				
14. FATHER'S NAME FIRST Fred				MIDDLE --				LAST Burnett				15. MOTHER'S MAIDEN NAME FIRST Minnie				MIDDLE Pearl				LAST BURNETT				16. ADDRESS Md. Ethel Burnett, 4606 Eugene Ave, Balto												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				(IF YES, GIVE WAR OR DATES) WWII				16b. SOCIAL SECURITY NO. 219-12-6831				17. INFORMANT ADDRESS Md. Ethel Burnett, 4606 Eugene Ave, Balto																								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) A.S.C.V.D. DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																				
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?																20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY				STATE																
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																				
ACTUAL SIGNATURE Luis E. Kenjel				TITLE (SPECIFY) Deputy MEDICAL EXAMINER																DATE SIGNED 12/21/79																
EXAMINER'S NAME (TYPE OR PRINT) Luis E. KENJEL, M.D.				ADDRESS 464 ALLIANCE ST. HARFORD MD.																																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Dec 24, 1979				23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens				23d. LOCATION CITY OR TOWN Bel Air				COUNTY Harford				STATE MD.																
24. FUNERAL DIRECTOR NAME Howard K. McComas III												ADDRESS Abingdon, Md.												25a. DATE REC'D. BY REGISTRAR DEC 24 1979				25b. REGISTRAR'S SIGNATURE Pistroy Melnyk								

Blank lined paper with two punch holes on the right side. Faint, illegible handwriting is visible throughout the page, appearing as bleed-through from the reverse side. The text is mirrored and cannot be accurately transcribed.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 0 5 2 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Marjorie E. Burton								December 13, 1979		6 ¹⁰ A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS	
Female		White		Sept. 2 1922		57 YRS		MONTHS DAYS		HOURS MIN.	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH					
Md		U.S.A.				Harford					
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		14a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		14b. KIND OF BUSINESS OR INDUSTRY					
Harford		Harford Mem. Hospital		Housewife							
15a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		15b. CITY OR TOWN		15c. INSIDE CITY LIMITS?		15d. STREET ADDRESS					
Md. Harford		Whiteford		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4519 Fintville Rd.					
16. FATHER'S NAME		16. MOTHER'S MAIDEN NAME									
William A. Anderson		Jessie Morris									
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		17b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS					
No		213-16-6801		Thomas W. Burton		Whiteford, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
410 -											
DUE TO, OR AS A CONSEQUENCE OF (b) _____											
DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22. I certify that (I) (This hospital) attended the deceased from <u>12-12-79</u> to <u>12-13-79</u> that (I) (we) lost saw the deceased alive on <u>12-13-79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED					
Brian T. Yeo		M.D.				12/13/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Dr. Brian T. Yeo		Harford, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		12-17-79		Harford Mem. Gdn		Aldino, Harford, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
John H. Harkins		Delta, Pa.		DEC 18 1979		[Signature]					

2000 10 10



Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 0 5 3		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ELMER H CATON				2a. DATE OF DEATH MONTH DAY YEAR 12 7 79		2b. HOUR MIN 6 45 A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR OCT. 31, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTH PLACE (STATE OR FOREIGN) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
12. CITY OR TOWN OF DEATH FALLSTON		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION FALLSTON GENERAL HOSP		14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ASSEMBLER AUTO PLANT		15. KIND OF BUSINESS OR INDUSTRY			
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND				17b. COUNTY HARFORD		17c. CITY OR TOWN FALLSTON		17d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
18. FATHER'S NAME FIRST MIDDLE LAST GEORGE CATON				19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NANCY ALARIGHT					
20a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		20b. SOCIAL SECURITY NO. 212-10-6326		21. INFORMANT ADDRESS MRS. BRENDA BOLT, JOIPA, MARYLAND					
22. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute myocardial infarction 410- DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) hypertensive arteriosclerotic heart disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Diabetes Mellitus								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
23a. DATE OF OPERATION —		23b. CONDITION FOR WHICH OPERATION WAS PERFORMED		24a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		24b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
25a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		25b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		25c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
26a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		26b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		26c. LOCATION STREET CITY OR TOWN COUNTY STATE					
27. I certify that (I) (this hospital) attended the deceased from JUNE 19 79 to DEC. 7 19 79, that (I) (we) last saw the deceased alive on DEC 16 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
28a. SIGNATURE Ben Oteyza		28b. DEGREE M.D.		28c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		28d. DATE SIGNED 12/7/79			
29a. PHYSICIAN'S NAME (TYPE OR PRINT) BEN OTEYZA		29b. ADDRESS 1131 BALTIMORE PIKE, BEL AIR, MD.							
30a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		30b. DATE DEC. 11, 1979		30c. NAME OF CEMETERY OR CREMATORY JOHNSON CEMETERY		30d. LOCATION CITY OR TOWN COUNTY STATE FROSTBURG GARCET, MD.		30e. DATE REC'D. BY REGISTRAR	
31. FUNERAL DIRECTOR NAME DURST FUNERAL HOME, FROSTBURG, MD.		31b. ADDRESS		31c. DATE REC'D. BY REGISTRAR DEC 17 1979		31d. REGISTRAR'S SIGNATURE			

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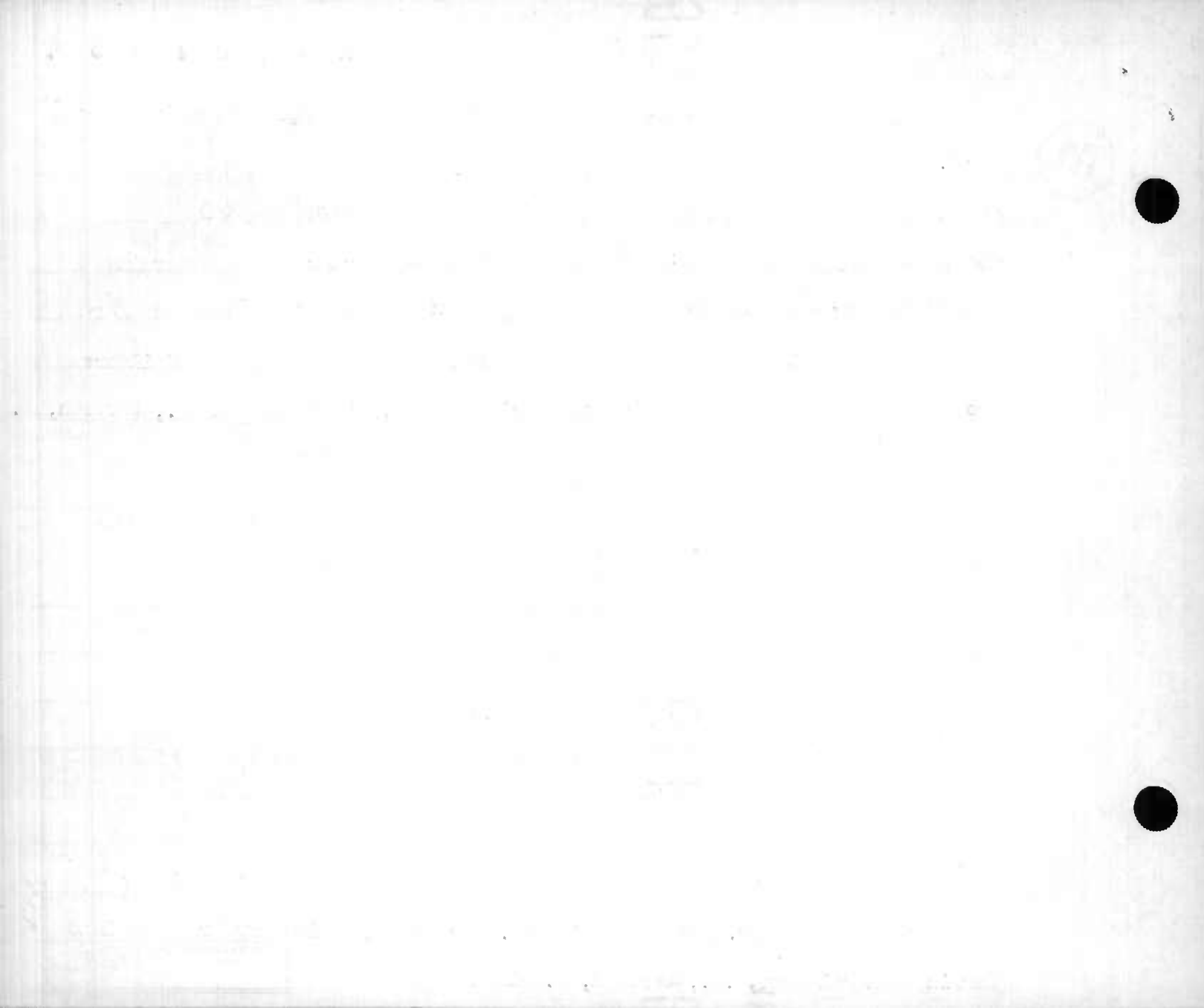
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 0 5 4 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERVIN Cicero CAUDILL			
2a. DATE OF DEATH MONTH DAY YEAR Dec. 4, 1979				2b. HOUR 4¹⁰ AM			
3. SEX MALE		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 7 9 1903		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HRS. MIN. 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVERDE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY HARFORD 13c. CITY OR TOWN Aberdeen				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1503 Tower Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan Childers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 215-05-3893		17. INFORMANT ADDRESS Marie Hammons, 3119 James Run Rd., Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-pulm. arrest DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC CHF + COPD + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last Electrolyte imbalance + Dehydration DUE TO, OR AS A CONSEQUENCE OF (c) Acute, CHD-pulm. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-31 , 19 79 , to 12-4 , 19 79 , that (I) (we) last saw the deceased alive on 12-4 , 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
22b. SIGNATURE A. H. CALON DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. H. CALON				22e. ADDRESS 611 S. UNION AVE, Haverde Grace Md. 21075			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 6 Dec. 1979		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Tarring Funeral Home, P.A., Aberdeen, Md. 21001				25a. DATE REC'D. BY REGISTRAR DEC 7 1979		25b. REGISTRAR'S SIGNATURE Jeffrey McCurdy	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM "PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

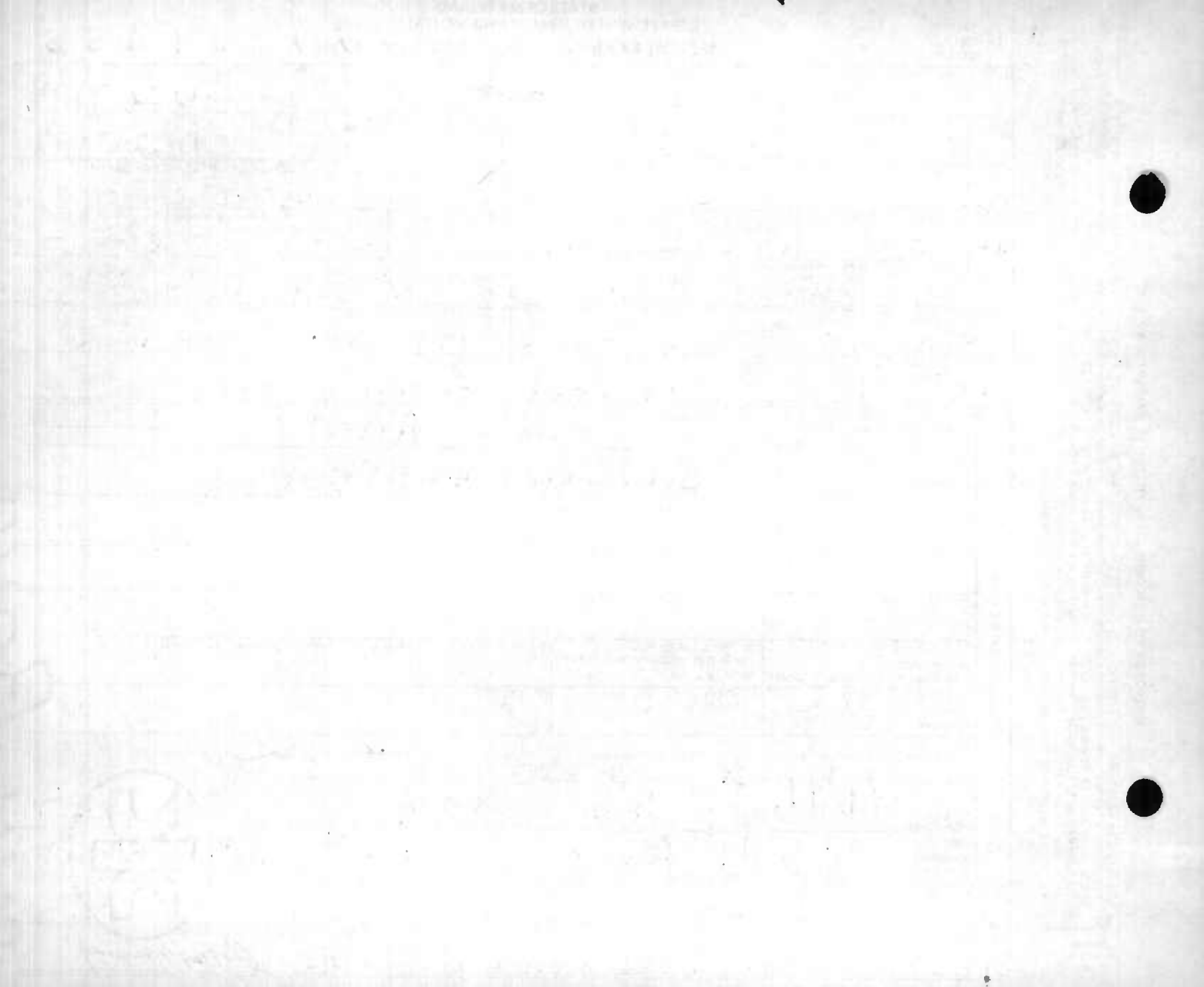
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(VR A15 ME (5))
30M 7/73

1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 9

REG. NO. 31055

1. DECEASED NAME (TYPE OR PRINT)		FIRST Cleland		MIDDLE F.		LAST Christopher		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH 12		DAY 22		YEAR 1979		2b. HOUR 9:00 AM	
3. SEX M		4. RACE Cauc		5. DATE OF BIRTH MONTH OCT.		DAY 24		YEAR 1903		6. AGE (IN YEARS) LAST BIRTHDAY 76 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE		13b. CITY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS									
14. FATHER'S NAME FIRST FREDERICK		MIDDLE		LAST CHRISTOPHER		15. MOTHER'S MAIDEN NAME FIRST MARGARET		MIDDLE BIGGER		LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
no		218-01-0976		FAMILY RECORDS													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac Arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY M.D.				MEDICAL EXAMINER				DATE SIGNED					
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS													
Willard P. Amoss				2404 Pleasantville Rd				Fallston Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				12-26-1979				Meadow Ridge				Baltimore Maryland					
24. FUNERAL DIRECTOR NAME				ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Evans Funeral Chapel				8800 Harford Rd				DEC 27 1979				Patricia Helms					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE MEDICAL EXAMINER. GIVE PAGE 5 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

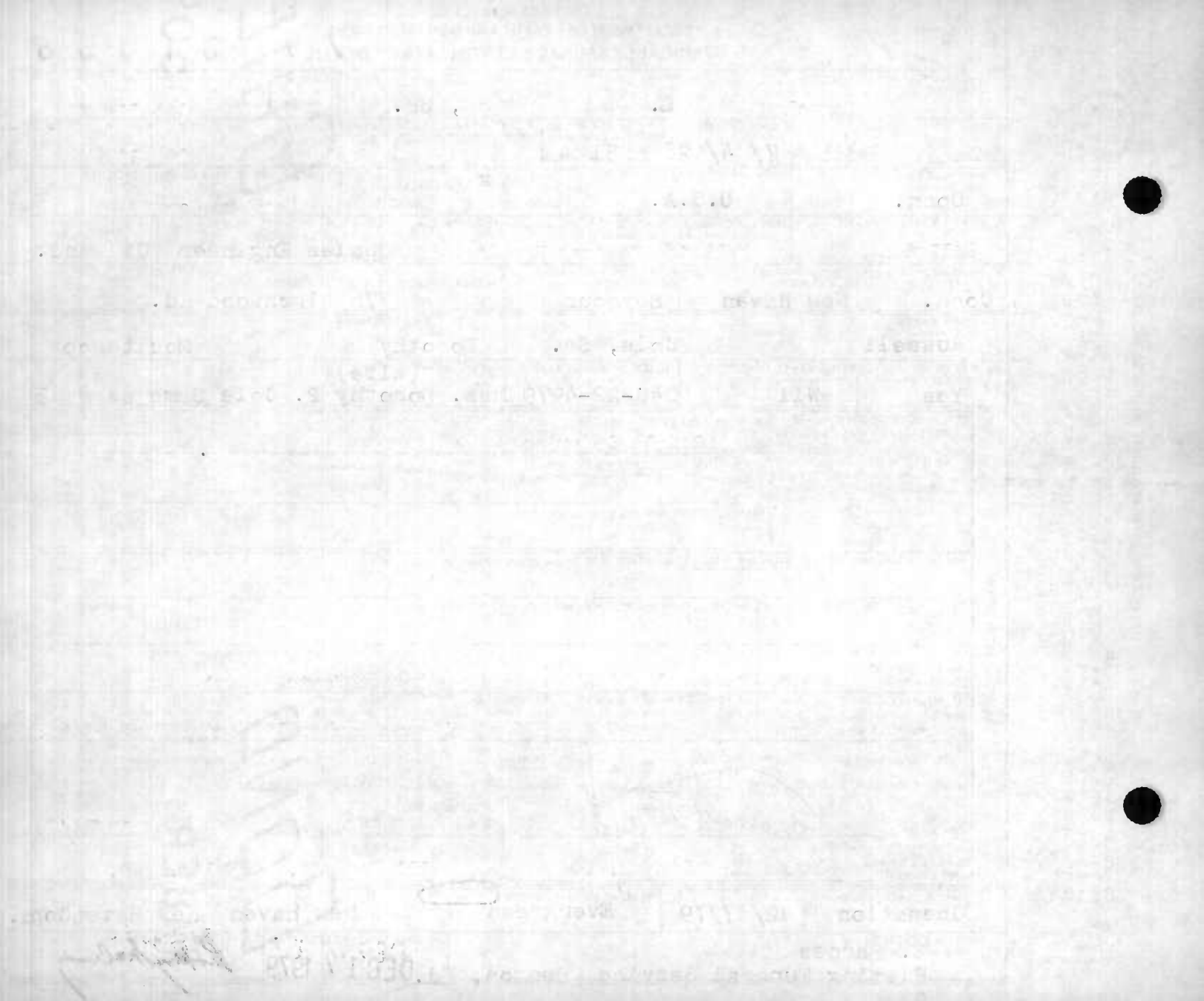
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DMMH - 17
(VR A15 ME (5))
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31056

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE	
Samuel L. Cole, Sr.		Male		White	
5. DATE OF BIRTH		6. AGE (IN YEARS)		7. DATE OF DEATH	
7/ 4/ 28		51 YRS.		12 13 19 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Conn.		U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Fallston		Fallston General Hospital-DOA		Sales Engineer	
13a. STATE		13b. CITY OR TOWN		13c. STREET ADDRESS	
Conn.		New Haven		78 Birchwood Rd.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	
Russell		Dorothy Moulthrop		Yes	
16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)		ADDRESS	
040-22-4979		Mrs. Dorothy P. Cole		Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Multiple injuries					
DUE TO, OR AS A CONSEQUENCE OF					
(b)					
DUE TO, OR AS A CONSEQUENCE OF					
(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		12 13 19 79 P.M.		driver in auto/auto impact	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION	
		street		I95 at milepostmarker 127 South, Harford Co., MD	
22a. I certify that I took charge of the remains described above, held in Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED	
Thomas D. Smith, M.D.		Deputy Chief		12/14/79	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		BALTIMORE, MD.	
Thomas D. Smith, M.D.		111 Penn St.		Balto., MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Cremation		12/17/79		Evergreen	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR	
E. Barnes		Fleming Funeral Service Benson, Md.		DEC 17 1979	
				25b. REGISTRAR'S SIGNATURE	
				Dorothy P. Cole	



Page 4

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DHMH - 16 25M

(VR A 15 (4)) 9/74

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										79 31057 REG. NO.			
1. FOR STATE REGISTRAR <i>WILLIAM FLOYD COX</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>12 3 79</i>		2b. HOUR <i>10 45 AM</i>	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>WILLIAM FLOYD COX</i>													
3. SEX <i>M</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>Jan. 9, 1913</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>66</i> YRS			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford County</i> MD.				
10. CITY OR TOWN OF DEATH <i>Fallston</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Cabinetmaker</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>US-govt. Ret.</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Bel Air</i>		13d. INSIDE CITY LIMITS? <i>YES</i> <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>5 N. Kelly Avenue</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Alvin Pete Cox</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Carrie Ella Price</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>			16b. SOCIAL SECURITY NO. <i>228-07-2417</i>			17. INFORMANT ADDRESS <i>Mrs. E. Nancy Cox, Bel Air, Md.</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Acute pulmonary embolism</i> <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of the lung</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec. 3</i> , 19 <i>79</i> , to <i>Dec. 3</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Brian T. Yeo</i> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								22c. DATE SIGNED <i>12/3/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>BRIAN T. YEO</i>								22e. ADDRESS <i>801 S. UNION AVE, HAVERDE GRACE MD. 21078</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>Dec. 6, 1979</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Mem. Gardens</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bel Air Harford Md.</i>				
24. FUNERAL DIRECTOR NAME <i>Howard K. McComas III, Abingdon, Md.</i>								25a. DATE REC'D. BY REGISTRAR <i>DEC 5 1979</i>		25b. REGISTRAR'S SIGNATURE <i>John H. Brady</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP
DHMH - 16 60M 7/73
(VR A 15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 31058

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EMORY LAVINSON COYLE		2a. DATE OF DEATH MONTH DAY YEAR 12-17-79		2b. HOUR 5 4 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR December 18, 1893		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KANSAS	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH FALLSTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator	12b. KIND OF BUSINESS OR INDUSTRY Glass Blower
13a. STATE Maryland		13b. COUNTY Harford Co.	13c. CITY OR TOWN Bel Air	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William CLARENCE COYLE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha JANE McMINN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW I - Army	17. INFORMANT (Last, first, middle) Miss Catherine L. Coyle Bel Air, Maryland 21014	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery</u> 436 - DUE TO, OR AS A CONSEQUENCE OF (b) <u>Poisoned Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>C.V.A.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17/79</u> to <u>12/17/79</u> , that (I) (we) last saw the deceased alive on <u>12/17/79</u> and that in (my) (our) opinion death occurred on this date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 12/17/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V. S. NAIR MD		22e. ADDRESS 200 Milton Ave Fallston		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 19, 1979	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co., Maryland 21014		23e. DATE REC'D. BY REGISTRAR DEC 18 1979		
24. FUNERAL DIRECTOR Joseph William Foster Superior Funeral Home		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

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OFFICE OF THE
DIRECTOR OF THE
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR OFFICE. GIVE PAGE 6 TO THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31059	
1. DECEASED NAME (TYPE OR PRINT) Walter L. Crispens, Sr.										2a. DATE KNOWN OF DEATH 12/13/79	
3. SEX M 4. RACE Cauc 5. DATE OF BIRTH Oct. 7, 1903 6. AGE (IN YEARS) 76 YRS. 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 12/13/79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.											
10. CITY OR TOWN OF DEATH Fallston 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital 12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemical Operator -											
13a. STATE Md 13b. COUNTY Harford 13c. CITY OR TOWN Edgewood 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 602 Yorkshire Ct.											
14. FATHER'S NAME David Crispens 15. MOTHER'S MAIDEN NAME Allaise Kacer											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 216-01-9332 17. INFORMANT Walter Crispens, Jr., Ct. B, Edgewood Md										ADDRESS 602 Yorkshire Dr	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic Heart Disease (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Willard P. Amoss M.D.				TITLE (SPECIFY) Asst. Dir. MEDICAL EXAMINER				DATE SIGNED 12/13/79			
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss				ADDRESS 2404 Pleasantville Rd, Fallston, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/17/79		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FURNITURE Schimunek Funeral Home, Inc.				ADDRESS 9705 Belair Rd. Balto., Md. 21236				25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE Robert M. Brady	

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Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

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Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

Section 10, Township 10N, Range 10E, T10N, R10E, S10

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 0 6 0

REG. NO.

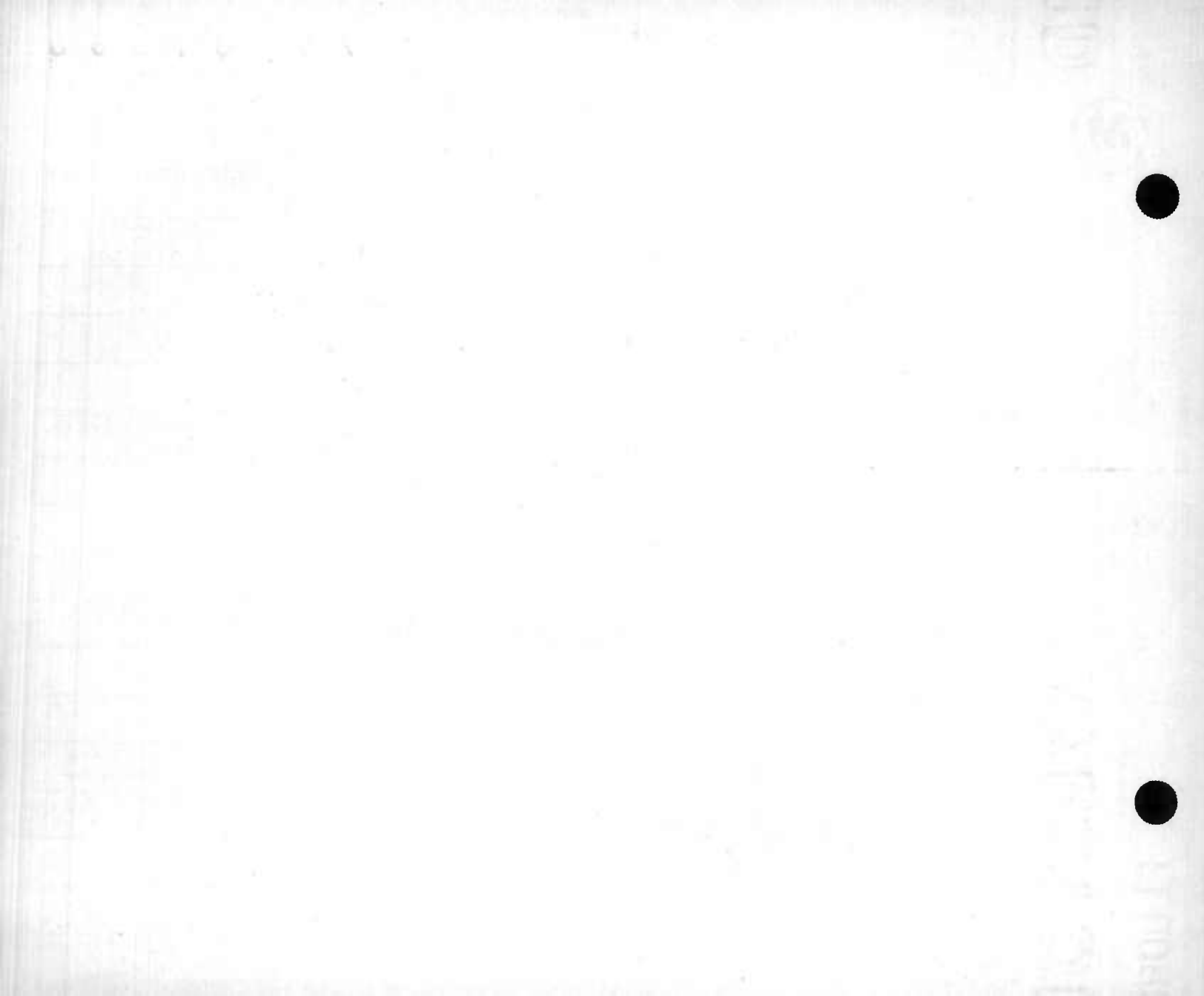
1- FOR STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EARL WILLIAM CULLUM SR.		2a. DATE OF DEATH MONTH DAY YEAR 12-6-77		2b. HOUR M	
3. SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR Sept. 1, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10 CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY general	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Harford Aberdeen				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2421 Carsins Run Road	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Winfield Cullum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah -- Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-1907		17 INFORMANT ADDRESS Mary Cullum, Aberdeen, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure - Pneumonic Process</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Infarction (L) Hemisphere</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION 11/9/77		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Gastric & Duod. ulcer, Ventral		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) Accident			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-4-77, 1977, to 12-6-77, 1977, that (I) (we) last saw the deceased alive on 12-6-77, 1977, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles J. Foley, M.D.				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES J. FOLEY JR M.D.				22e. ADDRESS HARFORD DE GRACE, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 10, 1977		23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Churchville-Harford-Md.	
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR DEC 10 1977		25b. REGISTRAR'S SIGNATURE Dorothy McC...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH7 9 3 1 0 6 1
REG. NO.1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Frank John Dauer			2a DATE OF DEATH MONTH DAY YEAR 12-30-79		2b HOUR 7:34 AM
3 SEX Male	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR 03 27 94	6 AGE (IN YEARS (LAST BIRTHDAY)) 85 85 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD		
10 CITY OR TOWN OF DEATH Fallston	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Streetcar Motorman	12b KIND OF BUSINESS OR INDUSTRY Transportation	
13a STATE Bel Air Md			13b CITY OR TOWN Bel Air	13c STREET ADDRESS 1530 Cedarwood Dr.	
14 FATHER'S NAME FIRST MIDDLE LAST Charles Dauer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora Gumbert		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES-NAVY		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW. I	17 INFORMANT (NAME) ADDRESS Ben 879-2152 1530 Cedarwood Drive Bel Air, Maryland 21014		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Arteriosclerotic Disease with stroke DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Cholecystitis - Severe; Cholelithiasis & Obstructive Jaundice					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from 12/26 to 12/30, 1979, that (I) (we) last saw the deceased alive on 12/29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE Willard P. Amoss		DEGREE MD		22c DATE SIGNED 12/30/79	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Willard P. Amoss		22e ADDRESS 2404 Pleasantville Rd Fallston, Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE JAN 2, 1980		23c NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	
23d LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Co, Maryland 21014		23e DATE REC'D. BY REGISTRAR 23f. REGISTRAR'S SIGNATURE JAN 2 1980 [Signature]			
24 FUNERAL DIRECTOR Joseph William Foster [Signature] Bel Air, Maryland 21014					

1- FOR STATE REGISTRAR

2- TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

3- TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified promptly.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 6 2 REG. NO.	
1. FOR STATE REGISTRAR DECEASED NAME (TYPE OR PRINT) Rose B. Dermont						2a. DATE OF DEATH MONTH DAY YEAR Dec 21, 1979		2b. HOUR 11:50 A.M.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 07 27 20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.					
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (EMPLOYER WORK FOR MOST OF WORKING LIFE) Seagrave Factory		12b. KIND OF BUSINESS OR INDUSTRY Social Serv.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Pylesville			13b. COUNTY Harford		13c. CITY OR TOWN md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4050 Grandview Dr.		
14. FATHER'S NAME FIRST Charles MIDDLE -- LAST Mozine				15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE -- LAST Gervasi							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 156-05-2030		17. INFORMANT ADDRESS Day Funeral Home, Red Bank, New Jersey							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia (septic emboli) 4210 DUE TO, OR AS A CONSEQUENCE OF (b) Subacute Bacterial Endocarditis SMO DUE TO, OR AS A CONSEQUENCE OF (c) Infected Mitral Valve APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 wks											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) chronic coronary arterial failure + CVA.											
19a. DATE OF OPERATION 12/15/79		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED infected small bowel		19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12/13/79 to 12/20/79 , that (I) (we) last saw the deceased alive on 12/20/79 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE MBL				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/20/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE Dec. 21, 1979		23c. NAME OF CEMETERY OR CREMATORY Day Funeral Home		23d. LOCATION CITY OR TOWN COUNTY STATE Red Bank, Monmouth - N.J.					
24. FUNERAL DIRECTOR NAME Howard K. McComas III ADDRESS Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE Anthony McCreedy					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 0 6 3
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE JANE LAST Ecalono		2a. DATE OF DEATH MONTH DAY YEAR December 11, 1979		2b. HOUR 4:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1922	
6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois		8. CITIZEN OF WHAT COUNTRY? U.S.A.	
9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.		10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Mem. Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS 532 Beards Hill Road	
13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. CITY OR TOWN Aberdeen		13d. STATE Md.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph J. D. Amico		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Antonette DiMuzzio		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO. 220-07-8025		17. INFORMANT Mr. Domenico John Ecalono		17. ADDRESS 532 Beards Hill Rd. Aberdeen, MD. 21001	
18. CAUSE OF DEATH (Enter only one cause per item for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute Myocardial Infarction</u> (c) <u>As a consequence of</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>12-11</u> , 19 <u>79</u> , to <u>12-11</u> , 19 <u>79</u> , that (I) (we) lost the deceased alive on <u>12-11</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (she) (it) (did) (did not) view the body after death.			
22b. SIGNATURE <u>D. U. Monakil</u>		DEGREE M.D.		22c. DATE SIGNED 12/11/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. U. MONAKIL, LS GALVEZ, M.D. P.A.		22e. ADDRESS 622 S. Union Avenue Havre de Grace, Md. 21078		22f. MEDICAL PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/14/79		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto. MD.		24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, E. DEC 13 1979 8728 Liberty Road Randallstown, MD. 21133			

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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(VRA 15, 4) 7/78

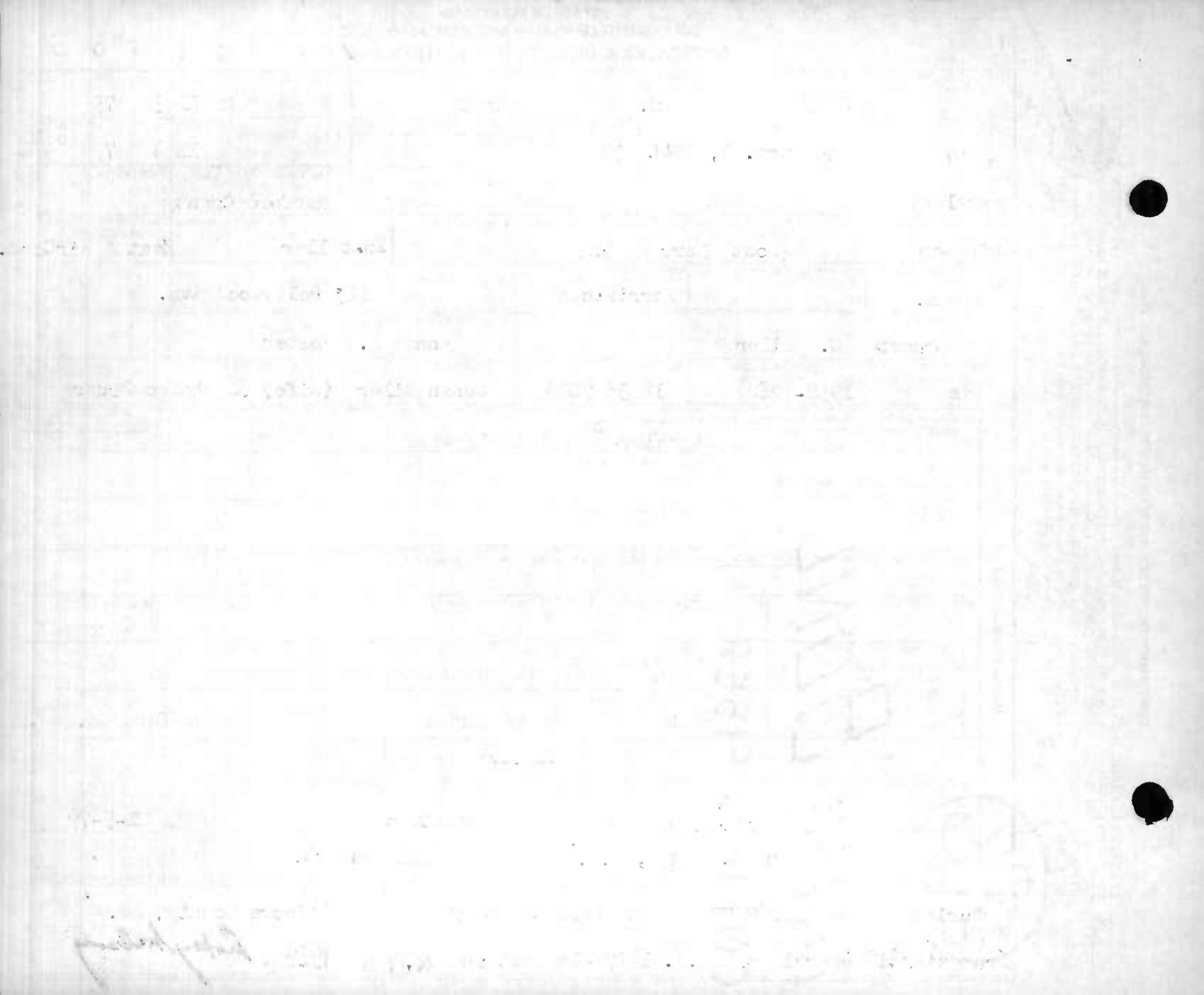
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 3 1 0 6 4
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
EMMA						EDWARDS		Dec.		13	79	10 ³⁰ AM			
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS						
Female	Black		3 12 92		87 YRS		MONTHS		DAYS		HOURS		MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Alabama	USA				HARFORD										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
HARFORD		HARFORD MEMORIAL													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Md		HARFORD		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1416 Perrywood DR							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Edward		Williams		Arrese		Raine									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
No		422-05-7423		MARY DAILEY		801 GARFIELD RD									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4379		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				DUE TO, OR AS A CONSEQUENCE OF											
				(c) 3/6 leg amputation											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> 19 <u>79</u> , to <u>12/13</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/13</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
		H. VANAKAWA M.D.		319 So. Union Ave. HARFORD MD.		12/13/79									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS													
H. VANAKAWA M.D.		319 So. Union Ave. HARFORD MD.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL		12-19-79		ST. JAMES		HARFORD									
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ARNOLD W. BEARD FUNERAL SERVICE		NORTH EAST, MD. 1176 CECIL AVE		DEC 21 1979		R. J. McHenry									

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G538 12/31/79 rSTATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 9											
REG. NO. 3 1 0 6 5											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR	
JOHN		T.		EILER				11 3 1979		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR
male	white	Oct. 1, 1940		39 YRS.					11 4 1979		6:10 p M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA		WIDOWED		DIVORCED		Harford County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Abingdon		(boat) Barr Harbor				Installer		Heat & AirCond.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Penna.				Norristown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		105 Hollywood Ave.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Ernest C. Eiler				Anna M. Foster							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
Yes		1958-1962		218 36 7029		Susan Eiler (Wife)		62 Shawgo Square			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Ethchlorvynol intoxication											
9502											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				? P.M. 11/3/ 19 79		Ingested overdose of drug					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
				boat		Barr Harbor				Harford Co. Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED			
Ann M. Dixon, M.D.				Assistant				11-5-79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
				111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		11/7/79		Oak Lawn Cemetery		Baltimore County, Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Bruzdzinski Funeral Home P.A. 1407 Old Eastern				NOV 8 1979				[Signature]			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7931066

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ruth L. Fisher			2a. DATE OF DEATH MONTH DAY YEAR December 17, 1979			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 11, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.			
10. CITY OR TOWN OF DEATH Edgewood		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2515 Hanson Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Onden Waiter		12b. KIND OF BUSINESS OR INDUSTRY Mail Onden	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE 2559 Md.		13b. COUNTY ✓		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2559 South Dene Ave. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel G. Huntabergen				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances M. Jumper					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-28-5165		17. INFORMANT James M. Fisher			
						ADDRESS Edgewood, Md., 21040 2515 Hanson Rd.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic cancer from colon</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1539			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <u>11-20</u> , 19 <u>79</u> to <u>12-13</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-13</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.							
22b. SIGNATURE <u>K. HANIF MD</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12 18 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. HANIF MD		22e. ADDRESS 5808 Main St., ELK RIDGE, Md 21220					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 20, 1979		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Balt., Md.	
24. FUNERAL DIRECTOR NAME McGully Funeral Home, 237 Patapsco Ave., Baltimore, Md. 21225				25a. DATE REC'D. BY REGISTRAR DEC 20 1979		25b. REGISTRAR'S SIGNATURE <u>Robert McHenry</u>	



BP

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(VR A15 ME (5))
15M 7/77

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR <i>Delphia</i>										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. <i>31061</i>				
1. DECEASED NAME (TYPE OR PRINT) <i>Delphia Theo Fox</i>										2a. DATE KNOWN OF DEATH ESTIMATED <i>12 19 79</i>										2b. HOUR				
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>12 28 14</i>		6. AGE (IN YEARS) LAST BIRTHDAY <i>64 YRS.</i>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <i>12 19 79</i>		2d. HOUR		2e. HOUR										
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WEST VA.</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <i>HARFORD CO.</i>				MD.								
10. CITY OR TOWN OF DEATH <i>ABERDEEN</i>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>4839 Philadelphia Road</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Coil Winder</i>				12b. KIND OF BUSINESS OR INDUSTRY <i>Bendix</i>								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																								
13a. STATE <i>MD</i>		13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>ABERDEEN</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4839 Philadelphia Rd</i>																
14. FATHER'S NAME FIRST MIDDLE LAST <i>ABRAHAM NMI Bumgardner</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LEE Carrico</i>																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>no</i>					16b. SOCIAL SECURITY NO. <i>316-20-9241</i>					17. INFORMANT ADDRESS <i>John E. Fox, Aberdeen, Md.</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): <i>1990 CARCINOMATOSIS</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b): <i>ADENOCARCINOMA</i> (c):										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																								
ACTUAL SIGNATURE <i>Luis E. Renjel</i>										TITLE (SPECIFY) M.D. <i>DEPUTY</i> MEDICAL EXAMINER										DATE SIGNED <i>12/19/79</i>				
EXAMINER'S NAME (TYPE OR PRINT) <i>Luis E. Renjel, M.D.</i>										ADDRESS <i>464 ALLIANCE ST. HARFORD CO. MD.</i>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>					23b. DATE <i>Dec. 19, 1979</i>					23c. NAME OF CEMETERY OR CREMATORY <i>Harbert F.H.</i>					23d. LOCATION CITY OR TOWN COUNTY STATE <i>Salem Harrison W. Va.</i>									
24. FUNERAL DIRECTOR NAME ADDRESS <i>Howard K. McComas III, Abingdon, Md.</i>										25a. DATE REC'D. BY REGISTRAR <i>DEC 21 1979</i>					25b. REGISTRAR'S SIGNATURE <i>History McCreedy</i>									

VOLUME

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FEB 10 1946
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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TO HOSPITAL ASSISTING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

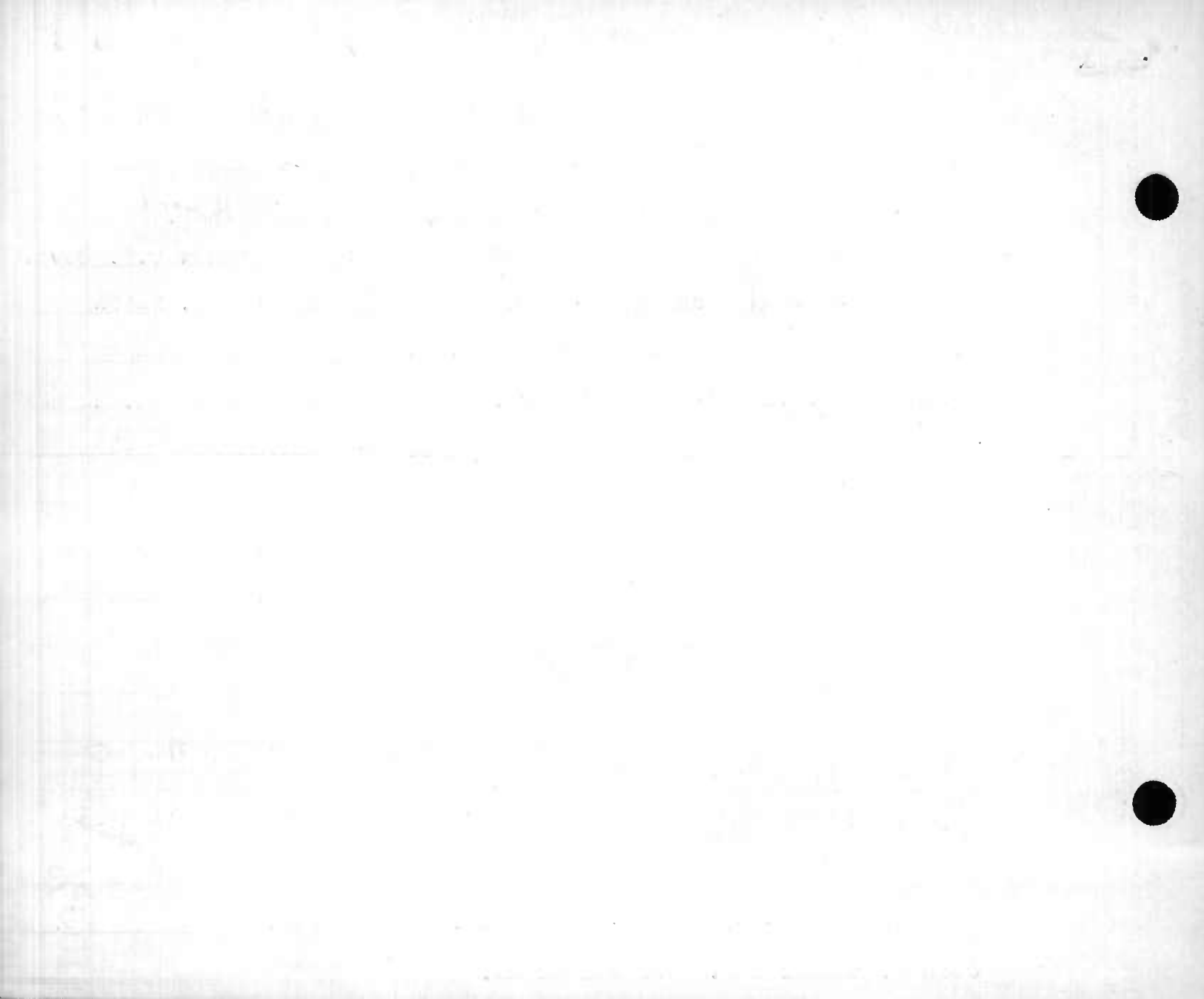
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 6 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) John Anton Fuenfgeld						2a. DATE OF DEATH MONTH DAY YEAR Apr 31 1979				2b. HOUR 6:50 PM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 10 16 91		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS				7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Engineer U.S. Govt.				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN Abertdeen		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 138 Edmund St. 21001					
14. FATHER'S NAME FIRST MIDDLE LAST John Fuenfgeld				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Linz									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I		17. INFORMANT ADDRESS Mrs. Helen Reed 138 Edmund St. 21001							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Cerebral thrombosis & rt. hemiplegia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Old age - Diabetes mellitus, Generalized arteriosclerosis										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 wk.			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-31-79 to 4-30-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) did (did not) view the body after death.													
22b. SIGNATURE Peter P. Rodman M.D.				DEGREE M.D.				22c. DATE SIGNED 1-1-80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 8 Low St. Abertdeen, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1-3-80		23c. NAME OF CEMETERY OR CREMATORY Immanuel Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.						25a. DATE REC'D. BY REGISTRAR JAN 9 1980		25b. REGISTRAR'S SIGNATURE Anthony McCready					

BP

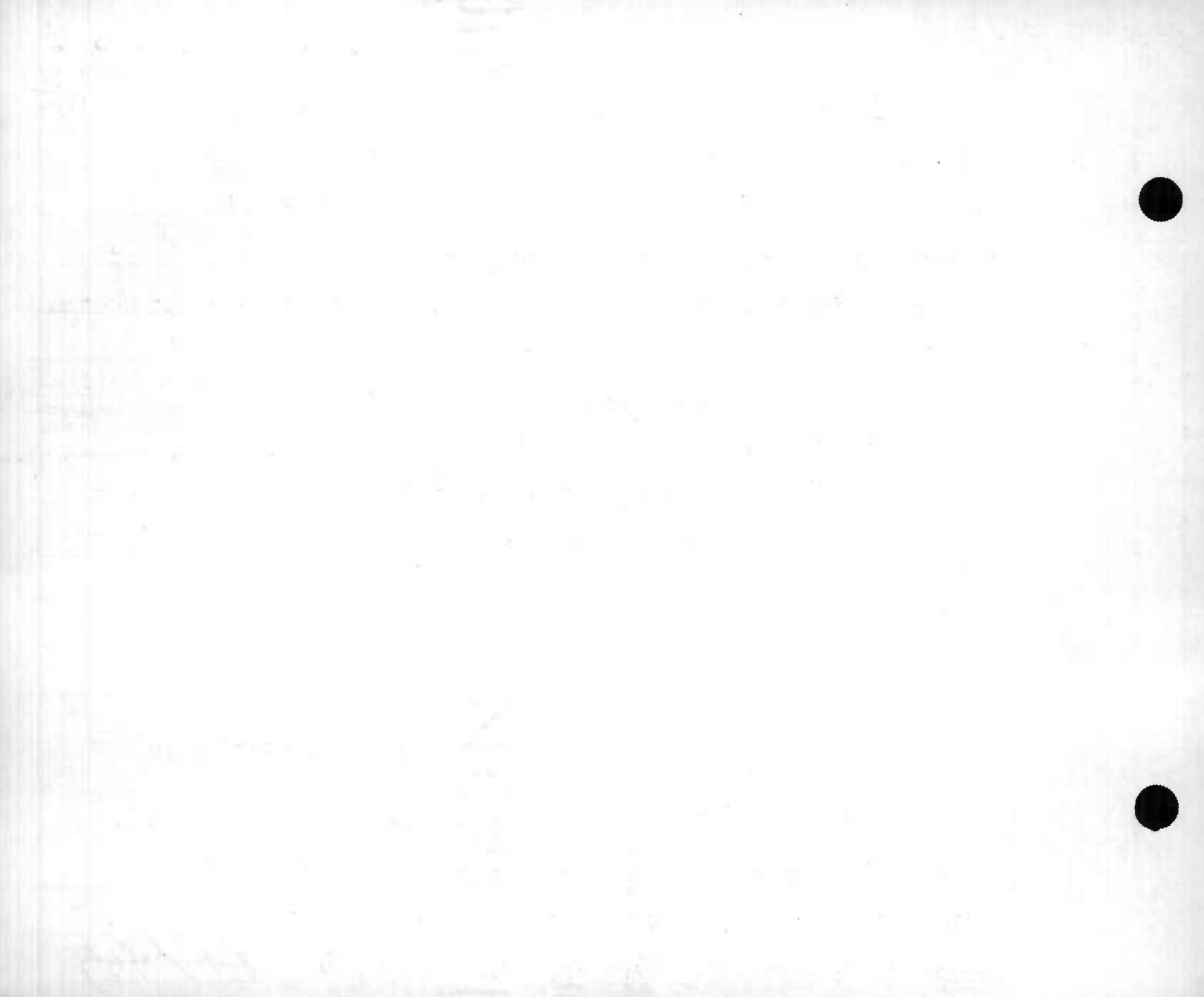


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
<div style="text-align: right;">7 9 3 1 0 6 9</div> <div style="text-align: center;">REG. NO.</div>									
1. DECEASED NAME (TYPE OR PRINT) JANE BAYS Gimmel					2a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1979			2b. HOUR 11 PM	
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Mar. 2, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 8. IF UNDER 74 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH HAURE de GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION, (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Self-empl.	
13a. STATE Md.		13b. COUNTY HARFORD		13c. CITY OR TOWN HAURE de GRACE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2145 Pulaski Highway	
14. FATHER'S NAME FIRST MIDDLE LAST James Aut Bays					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah -- Hayes				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 261-28-4070		17. INFORMANT ADDRESS James C. Bays, 13 Apache Drive, Aberdeen Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Failure 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Esophago-bronchial Fistula Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) Carcinoma of Esophagus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 9 months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-9 19 79 , to 12-25 19 79 , that (I) (we) last saw the deceased alive on 12-25 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE AW Grigoleit				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/26/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AW GRIGOLEIT				22e. ADDRESS HAURE de GRACE Md 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE L. F. H. H. H.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

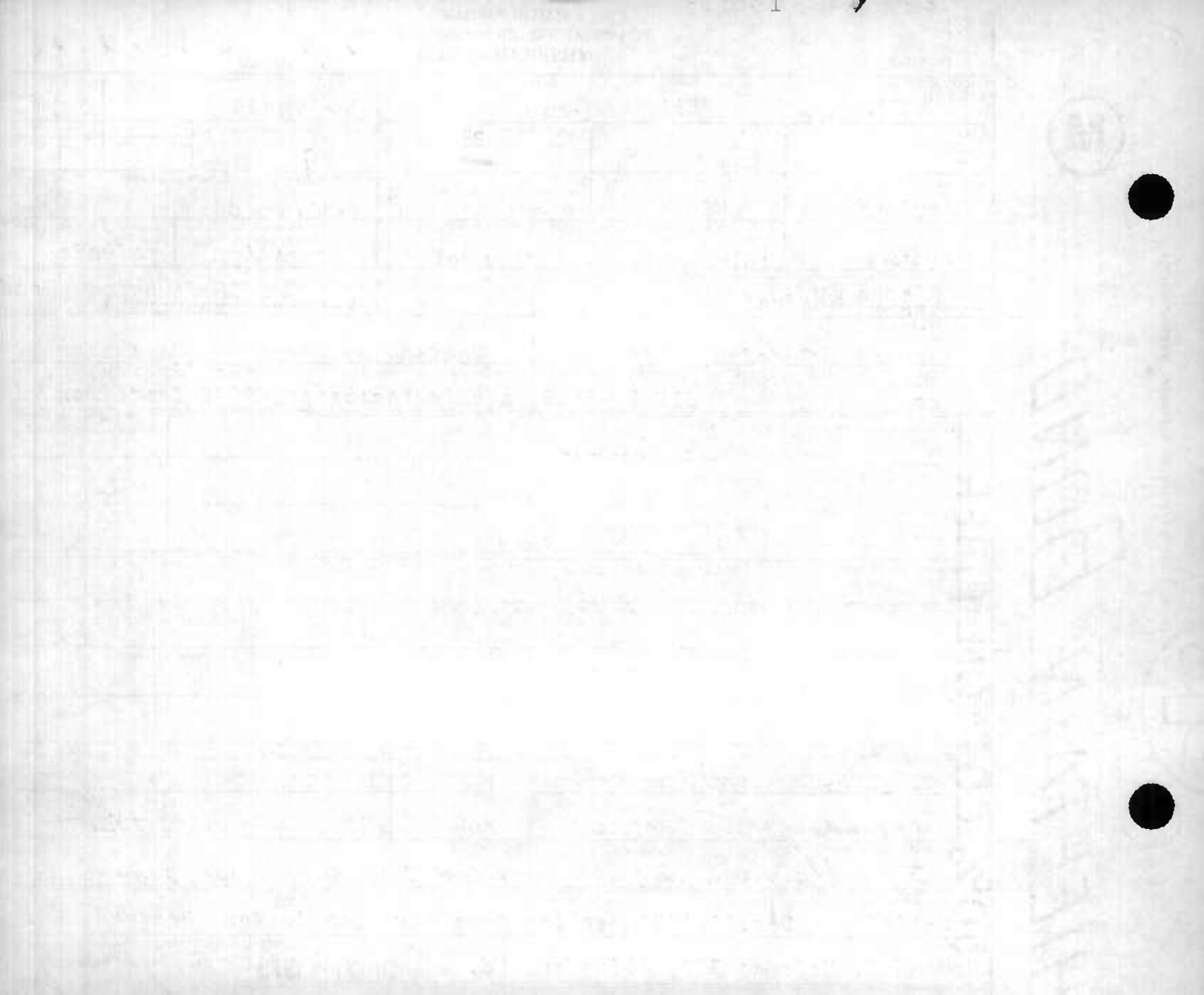
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO. 7 9 3 1 0 7 0						
1. DECEASED NAME (TYPE OR PRINT) Florence BELL Gray						2a. DATE OF DEATH MONTH DAY YEAR Dec 7, 1979		2b. HOUR 12:12 P.M.	
3. SEX F		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 11 28 20		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD			
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY private	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Joppa		13b. COUNTY Harford		13c. CITY OR TOWN md.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Howard Rudolph Gray		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Jane Presberry		13e. STREET ADDRESS 426 Dembytown Road 2700 Abingdon x x road					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 215-18-3629		17. INFORMANT ADDRESS Estella Presberry, 2245 Castleton Rd Darlington, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asystole 436- DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) CVA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1 Dec 19 79 to 7 Dec 19 79 , that (I) (we) last saw the deceased alive on 7 Dec 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Thaddeus E Harrison				DEGREE MD				22c. DATE SIGNED 7 Dec 79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T. E. Harrison MD				22e. ADDRESS FGH, 100 Milton Ave, 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 11, 1979		23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.			
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.				25a. DATE REC'D. BY REGISTRAR DEC 12 1979		25b. REGISTRAR'S SIGNATURE Antony McCurdy			

BP



TO HOSPITAL. ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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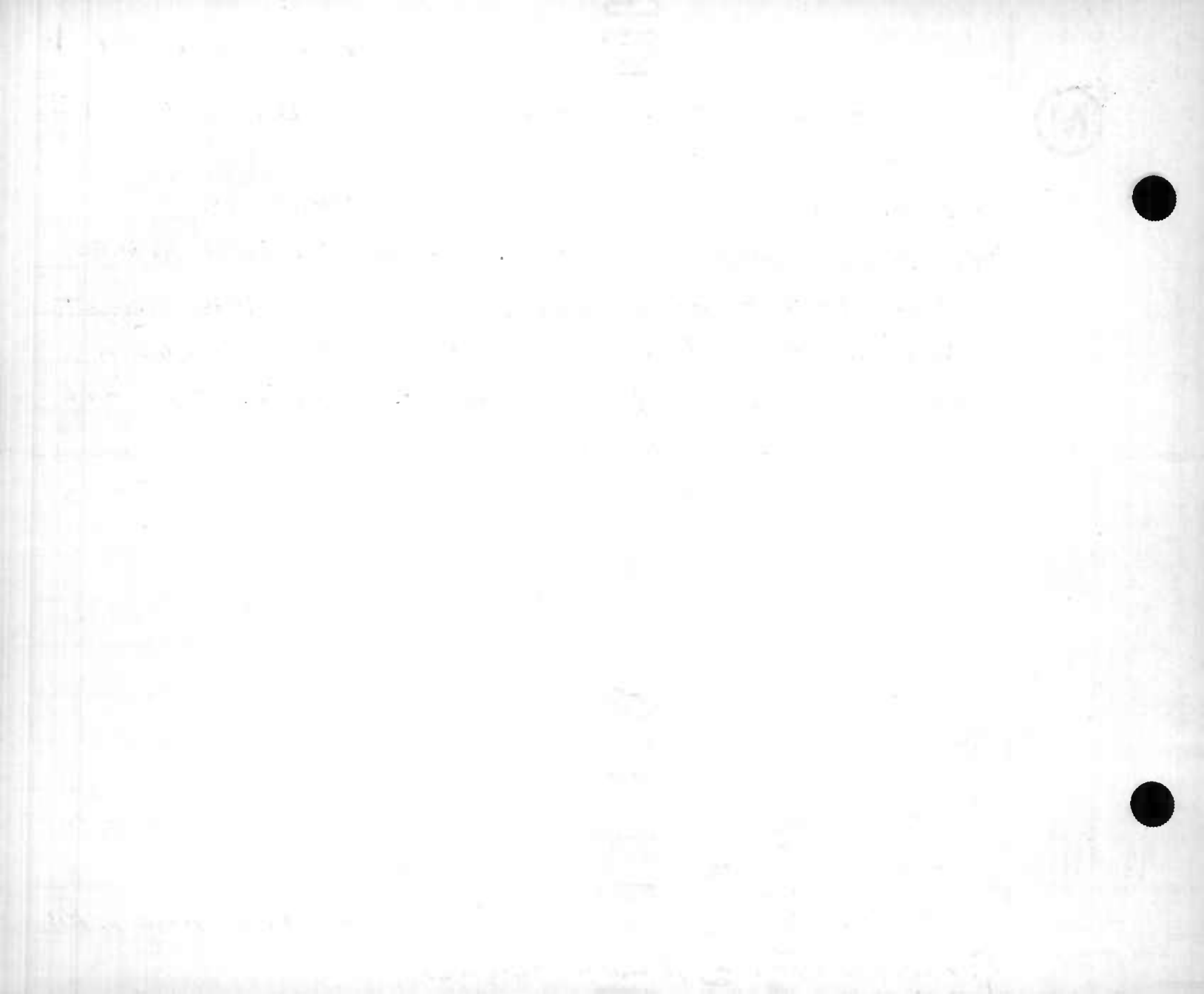
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 0 7 1

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		2c. MIN	
SAMUEL Henry GRIMSEY						Dec. 26, 1979		1		45	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		8. UNDER 24 HRS	
male		white		MONTH DAY YEAR July 24, 1917		67		MONTHS DAYS		HOURS MIN	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9b. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
LANCASTER, PA		U.S.A.				HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
HAVER de Grace		HARFORD Memorial Hospital		ASST. Post MASTER		RETIRED					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD.		HARFORD		HAVER de Grace				321 S. Washington, St.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST WILLIAM R GRIMSEY		FIRST MIDDLE LAST ETHEL - DRUMM									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
YES		W.W.I.I		221-05-7142		MRS. DORIS M. GRIMSEY		SAME			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		19. DUE TO, OR AS A CONSEQUENCE OF (b)		20. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		Hepatic Failure		Hepatic Metastases		8 months					
				Adenocarcinoma of Sigmoid colon		8 months					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-20, 19 79, to 12-26, 19 79, that (I) (we) lost the deceased on 12-26, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
A W GRIGOLEIT				12/26/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
A W GRIGOLEIT		HAVER de Grace, MD 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		12-29-79		ANGEL HILL CEM		HAVER de Grace, HARFORD, MD.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
R. MADISON MITCHELL		HAVER de Grace, MD		DEC 28 1979		Anthony McCreedy					



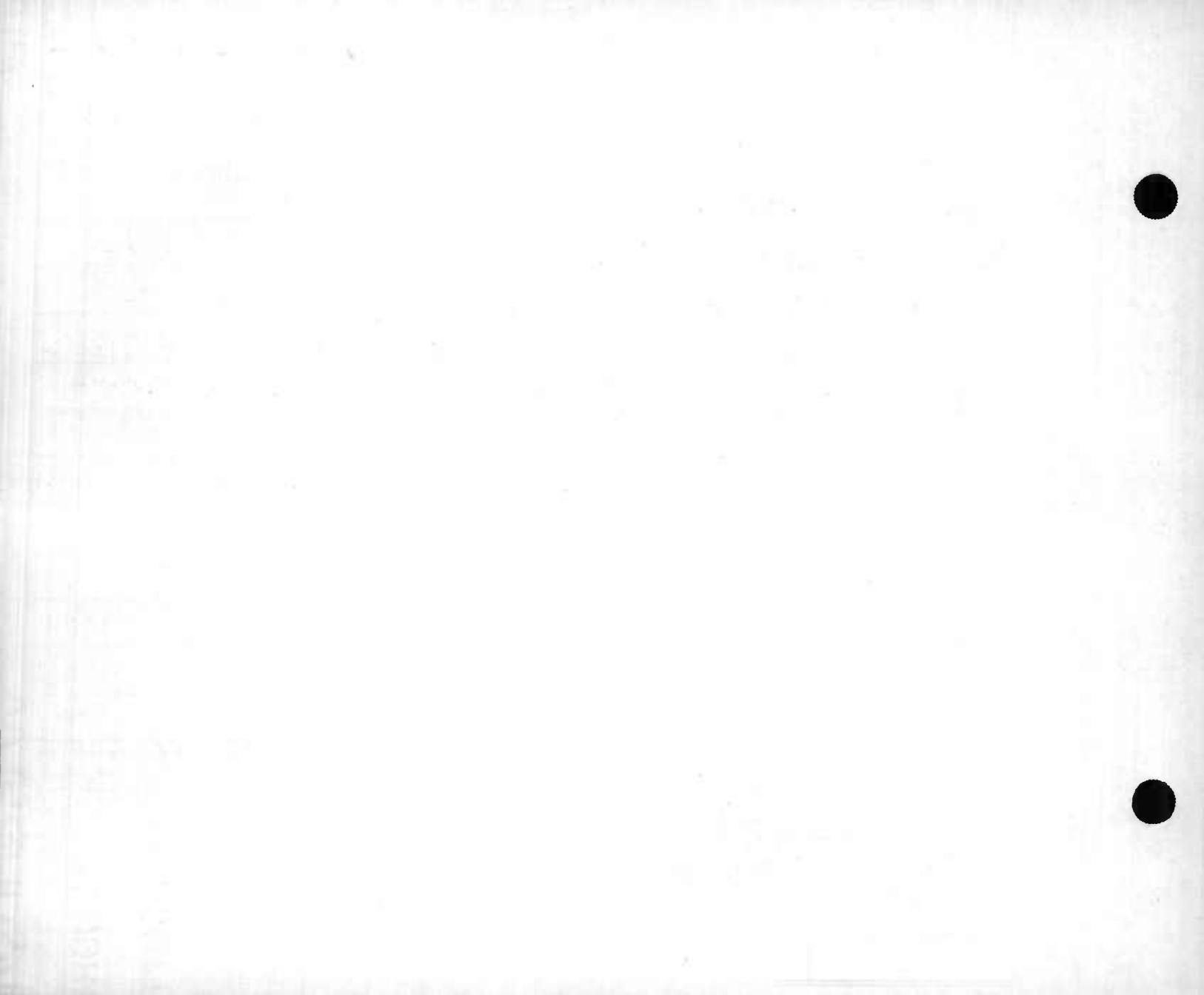
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 3 1 0 7 2				REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BABY BOY Grosweiler				2a DATE OF DEATH MONTH DAY YEAR 12-27-79				2b HOUR A M 6:08	
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MONTH DAY YEAR 12-27-79		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS 2 2		7b HOUR A M 2 2	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b CITIZEN OF WHAT COUNTRY? UNITED STATES		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10 CITY OR TOWN OF DEATH HARFORD		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		12b KIND OF BUSINESS OR INDUSTRY NONE	
13a STATE Md.		13b CITY OR TOWN HARFORD		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d STREET ADDRESS 1405 ONTARIO ST.			
14 FATHER'S NAME FIRST MIDDLE LAST HANS GEORGE PUKL				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JOYCE ANN ALLISON					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. NONE		17 INFORMANT ADDRESS HANS PUKL SAN JOSE, CALIFORNIA					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Don't know</u> 7620 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Stomach Cancer</u> (c) <u>intermittent</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> 19 <u>79</u> , to <u>12-27</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-27</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u>				22c. DATE SIGNED <u>12/27/79</u>				22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK HATEM	
22e. ADDRESS HARFORD DE GRACE, Md.				22f. ADDRESS HARFORD DE GRACE, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE DEC. 28, 1979		23c. NAME OF CEMETERY OR CREMATORY MT. ERIE		23d. LOCATION CITY OR TOWN COUNTY STATE HARFORD HARFORD MD			
24 FUNERAL DIRECTOR NAME Cunnington + Son		24b. ADDRESS Harford, Md.		25a. DATE REC'D. BY REGISTRAR JAN 1 1980					



3

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 31073									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH ESTIMATED		2b. HOUR	
Russell		T.		Guthrie		12/14/79		19		10:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)	IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2b. HOUR
M	Cauc	11/1/22		57 YRS.	MONTHS DAYS HOURS MIN				19		M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Harrison Co. MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Fallston		FALLSTON GENERAL HOSP.		Carpenter							
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md		Baltimore		Perry Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3918 Schroeder Ave.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Warren P Guthrie		Maggie Crabtree									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No		226-28-7660		Marion Guthrie		3918 Schroeder Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Cardiac Arrest											
DUE TO, OR AS A CONSEQUENCE OF											
(b) Arteriosclerotic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED			
Willard P. Amoss		Arrest						12/15/79			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
Willard P. Amoss		2404 Pleasantville Rd, Fallston, MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY STATE			
BURIAL		12-17-79		FORT HILL MEM. PK CEM		LYNCHBURG		VA			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
LASSAUN FUN'L HOME		7401 BELAIR RD.		DEC 19 1979							

MEDICAL CERTIFICATION

83

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TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

[Illegible text block]

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[Illegible text block]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 31074	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		2b. HOUR	
DELIA BILLINGS						HAROLD		12 31 '79		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
FEMALE		Cauc.		8 11 88		81		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
70 Wilkesboro N.C.		U.S.A.				HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF MOST OF LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
100 HARE DE GRACE		AT HOME 1325 KEEWEE LANE		HOUSEWIFE		SAME					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
35 Md.		HARFORD		HARE DE GRACE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1325 Kee Wee Lane			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
20 Mervie (Wm)		Billings		Ellen (Wm)		King					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
NO		NO		213 74.1900		ELLEN MARIE HAROLD		NORRIST WOODS 1325 Kee Wee Lane			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive arteriosclerotic</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebrovascular insufficiency</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Renal failure.</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> HOT WHILE <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>May 2</u> 19 <u>78</u> to <u>Dec</u> 19 <u>79</u> that (I) (we) lost saw the deceased alive on <u>Jan 17</u> 19 <u>79</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. DATE SIGNED							
A. MARIA KAWA M.D.		ATTENDING PHYSICIAN		12/31/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
A. MARIA KAWA M.D.		319 So. Union Ave. 1406 Md. 21078									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		1/3/1980		BELAIR MEMORIAL GARDENS		BELAIR HARFORD, Md.					
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Cunnington & Son		Hare de Grace, Md.		JAN 3 1980		[Signature]					

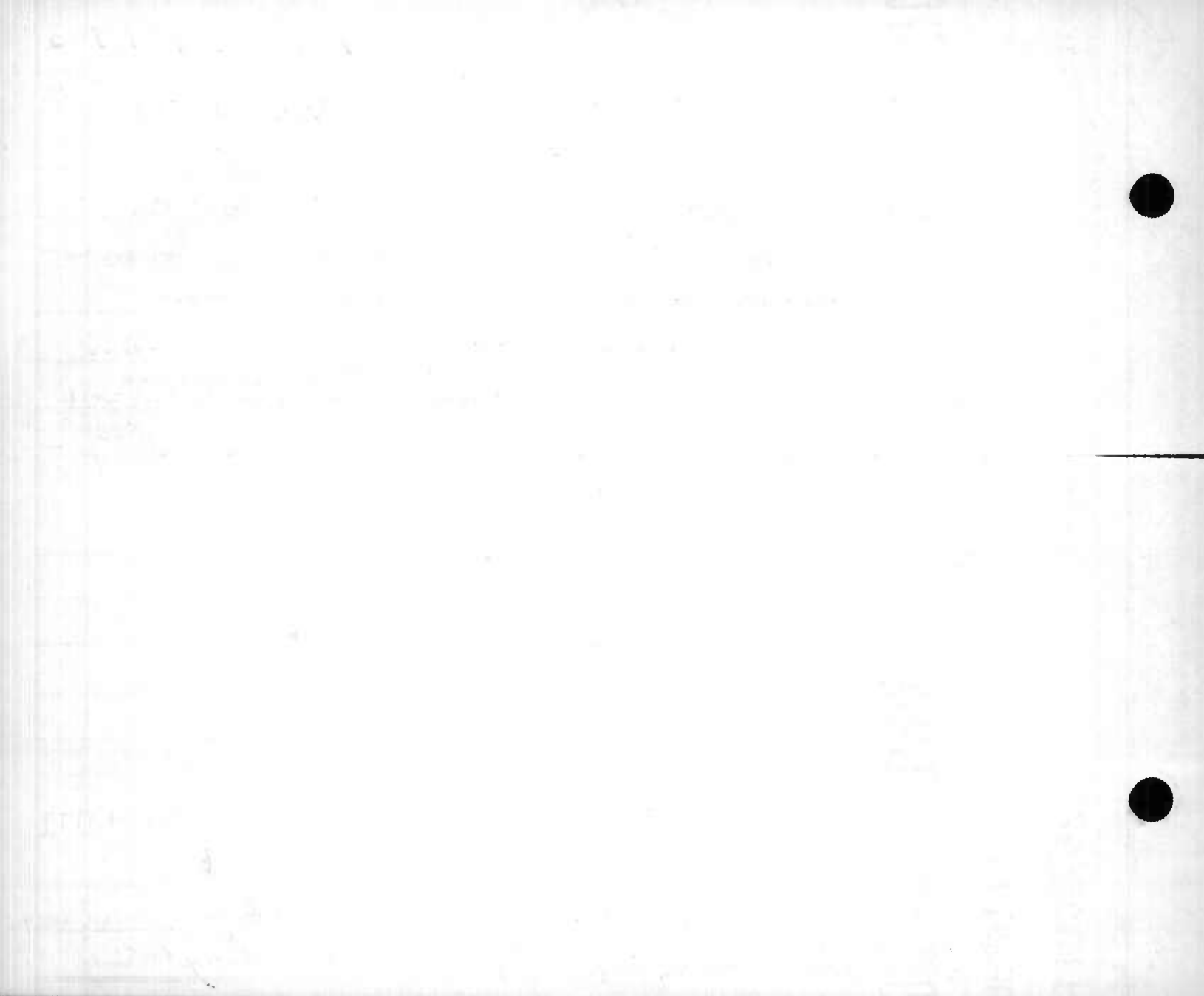
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				79 31075 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Grace Pearl Heck				2b. DATE OF DEATH MONTH DAY YEAR Dec. 12, 1979			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 13, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 94	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co. MD.	
10. CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Homemaker	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Harford Co. 13c. CITY OR TOWN Bel Air				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 21 Huntington Place			
14. FATHER'S NAME FIRST MIDDLE LAST James Frederick Herrman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Kate Elizabeth Harkins			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220-40-7844		17. INFORMANT (NAME) (ADDRESS) (GREAT NIECE) 21 Huntington Place Mrs. Sandra H. Dean Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>CVA</u> 436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH day -							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE A. de Coloron Jr. M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Dec. 14, 1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) de los Santos				22e. ADDRESS c. Humebrook Rd.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 15, 1979		23c. NAME OF CEMETERY OR CREMATORY Deer Creek Meth. Ch. Con.		23d. LOCATION CITY OR TOWN COUNTY STATE Forest Hill, Harford Co., Maryland 21014	
24. FUNERAL DIRECTOR Joseph William Foster Funeral Home				25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE L. H. Harkins	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 7 6	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isaac HOME Henry						2a. DATE OF DEATH MONTH DAY YEAR 12/ 15/ 79		2b. HOUR 9:40 P. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9 24 93		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County MD.					
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Air Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Gov. Distiller			
13a. STATE Maryland						13b. COUNTY Harford		13c. CITY OR TOWN Bel Air			
14. FATHER'S NAME FIRST MIDDLE LAST Oliver A. Henry						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Todd					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes - W-1		16b. SOCIAL SECURITY NO. Air Corps		17. INFORMANT (NAME) ADDRESS Mrs. Lillian C. Henry 330 North Williams Street Bel Air, Maryland 21014		18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 185- DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure due to Carcinoma 2 YRS DUE TO, OR AS A CONSEQUENCE OF (c) of Radium & metastasis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 Anemia Secondary to Radium / Pathological Fracture of Both Hips											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/24, 19 79, to 12/15, 19 79, that (I) (we) last saw the deceased alive on 12/10, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Linda Phillips MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dwight Phillips MD						22e. ADDRESS DARHINGTON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Dec 17, 1979		23c. NAME OF CEMETERY OR CREMATORY Security Process Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR Joseph William Foster		25a. DATE REC'D. BY REGISTRAR DEC 18 1979		25b. REGISTRAR'S SIGNATURE [Signature]							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

Item #5 per phone call w/ fun. Home										
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 7 9 3 1 0 7 7										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NORMAN Edward Henry					2a. DATE OF DEATH MONTH DAY YEAR 12 14 79		2b. HOUR 2:00 PM			
3 SEX MALE		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 15 15		6 AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.				
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Crane Operator		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Pennsylvania					13b. COUNTY -		13c. CITY OR TOWN New Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST William E. Henry					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Juliet R. Bond					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 216-03-2059		17 INFORMANT ADDRESS Jeannette M. Henry, same address			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. b) Acute myocardial infarction c) Acute myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 12-14-79 19 79 , to 12-14 19 79 , that (I) (we) lost saw the deceased alive on 12-14 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Brian T. Ye					DEGREE			22c. DATE SIGNED 12-14-79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRIAN T. YEO					22e. ADDRESS 801 S. Union ave, HAVERDE GRACE Md. 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/18/79		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland				
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc.					ADDRESS 8705 Belair Rd. Balto., Md. 21236		25a. DATE REC'D. BY REGISTRAR JEC 18 1979		25b. REGISTRAR'S SIGNATURE Anthony Maloney	

MEDICAL CERTIFICATION

1916

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the matter of the purchase of the land for the proposed new building for the University of Chicago Press.
The matter is being considered by the Board of Trustees and the Board of Directors of the Press.

I am, Sir, very respectfully,
Yours very truly,
The University of Chicago Press

Very truly,
The University of Chicago Press

Very truly,
The University of Chicago Press

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

7 9 3 1 0 7 8

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2. DATE OF DEATH		2b. HOUR	
Dorothy I. Herzberger				8 December 3, 1979		11:32 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		White		MONTH DAY YEAR		7. IF UNDER 1 YEAR	
				10 02 25		MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
md.		U.S.				Harford MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		Fallston General Hospital		homemaker		Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
md.		Harford		Joppa		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		13f. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		Joppa, Md. 21085		2607 Kenwood Drive	
William Spies		Mercedes Bandel					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
no		214-20-7162		Mr. Melvin L. Herzberger Sr.		2607 Kenwood Dr. Joppa, Md. 21085	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)							
PART 1. DEATH WAS CAUSED BY							
IMMEDIATE CAUSE (a) CARDIAC FAILURE							
4254 DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) 1010PATHIC CARDIOMYOPATHY							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)							
ORGANIC BRAIN SYNDROME							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from NOV. 30, 19 79, to DEC. 3, 19 79, that (I) (we) lost							
saw the deceased alive on DEC. 3, 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE M.B.B.S. M.R.C.P. ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
A.J. Sweatman						Dec. 3, 1979.	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
A.J. SWEATMAN		1317, Boyce Ave. BALTO. 21204.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12-6-1979		Cedar Hill Cemetery		Glen Burnie, Anne Arundel, Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
E.F. Lassahn, 11750 Belair Rd.,		Kingsville, Md. 21087		DEC 5 1979		Peter K. Rine	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					7 9 3 1 0 7 9 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Gloria L. Holder</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>12 24 79</i>			2b. HOUR <i>1240 PM</i>		
3. SEX <i>F</i>		4. RACE <i>C</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 9 32</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>42</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Baltimore</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Harford Co.</i> MD.				
10. CITY OR TOWN OF DEATH <i>Baltimore, Md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fallston General Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Beurician</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Adolphs</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE CITY OR TOWN <i>Maryland Baltimore Edgewood, Md</i>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>982 Top View Dr. 21040</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Conrad</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mildred Getsinger</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. <i>219 34 7087</i>		17. INFORMANT ADDRESS <i>Leroy J. Holder Sr. 982 Top View Dr</i>						
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pulmonary Embolus.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4151</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Asthma Seizure Disorder.</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>12/21</i> , 19 <i>79</i> , to <i>12/24</i> , 19 <i>79</i> , that (I) (we) last saw the deceased alive on <i>12/24/79</i> , 19 <i>79</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>St. Doughs Abbott</i>					DEGREE <i>MD</i>		22c. DATE SIGNED <i>12/24/79</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>St. Doughs Abbott</i>					22e. ADDRESS <i>Fallston General Hospital</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>12/28/79</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sacred Heart Of Jesus</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore Md</i>				
24. FUNERAL DIRECTOR NAME <i>Walter Dabrowski</i>					ADDRESS <i>1005 Dundalk Avenue</i>		25a. DATE REC'D. BY REGISTRAR <i>DEC 28 1979</i>		25b. REGISTRAR'S SIGNATURE <i>Jeffrey M. Crady</i>	

Editor: Barbara
1005 Dunbar Avenue

12/16/79

Sacred Heart of Jesus
Baltimore

MD

no

219 34 7057

Barry J. Holder Sr. 981 Top View Dr

Conrad

11148

1005 Dunbar

Maryland

Baltimore

Edgewood, MD

X

981 Top View Dr. 11000

Baltimore, MD

USA

1005 Dunbar

1005 Dunbar

Baltimore

USA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR 115 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31080

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDNA M. HOLLAND			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 12 31 19 79			2b. HOUR M		
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR Jan 14 1893	6. AGE (IN YEARS) (LAST BIRTHDAY) 86 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 31 19 79	2d. HOUR M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		
10. CITY OR TOWN OF DEATH HAVRE DE GRACE			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 644 Greene St			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE MD			13b. COUNTY HARFORD		13c. CITY OR TOWN Havre de Grace	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 644 Greene St.	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Sweeney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Dougherty			ADDRESS 8300 Bon Air Rd.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 190-12-1631		17. INFORMANT Mildred Brumfield (cousin)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY HEART DISEASE 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Luis E. Renjel			TITLE (SPECIFY) Deputy			DATE SIGNED 12-31-79		
EXAMINER'S NAME (TYPE OR PRINT) Luis E. Renjel			ADDRESS 464 Alliance St.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/80		23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION CITY OR TOWN COUNTY STATE York Penna.		
24. FUNERAL DIRECTOR Schimmunek Funeral Home, Inc.				ADDRESS 8705 Belair Rd. Balto. Md. 21236		25a. DATE REC'D. BY REGISTRAR JAN 3 1980		25b. REGISTRAR'S SIGNATURE Patricia McLeod

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TO HOSPITAL OR ATTENDING PHYSICIAN The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

BP _____

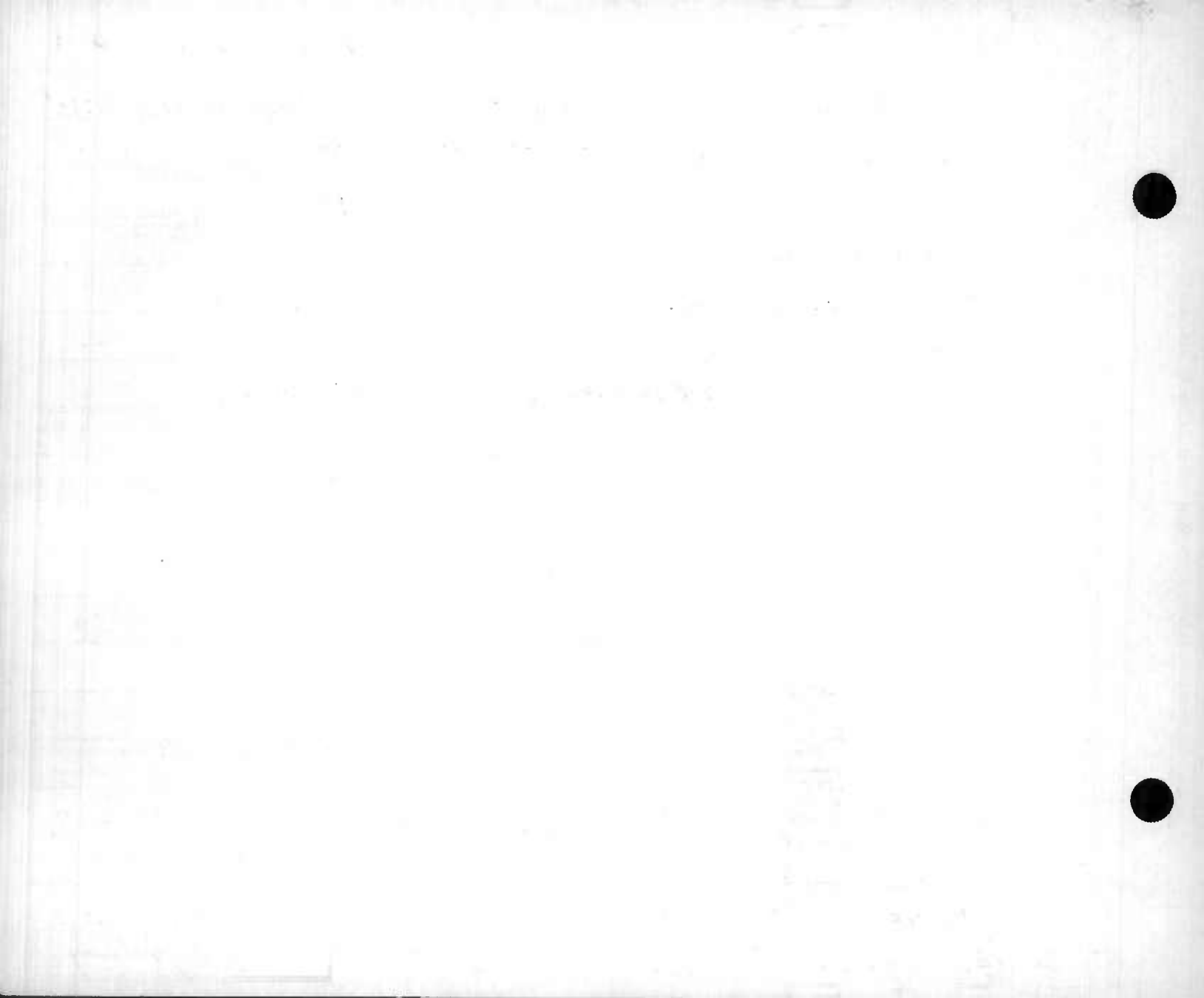
DHMH-16 20M
(VRA 15, 4) 7/78

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 8 1 REG. NO.					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME FIRST MIDDLE LAST Virginia Hueitt										Dec. 15, 1979				9:13 P.M.	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 5 18 34		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) V		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD									
10 CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 46 SWAN ST.			
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN											
14 FATHER'S NAME FIRST MIDDLE LAST ROY GILES				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH HUEITT											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 21532 8540		17 INFORMANT ELIZABETH PUGH		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Respiratory arrest 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of esophagus DUE TO, OR AS A CONSEQUENCE OF (c) terminal stage 6 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from October 30, 1979, to Dec 15, 1979, that (I) (we) last saw the deceased alive on 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE M. Jeseda				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Jeseda M.D.				22e. ADDRESS 615 S. Union Ave. Hdr											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORY CHESNUT GROVE		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKS HA MD							
24. FUNERAL DIRECTOR NAME GEORGE W. TITTLE						ADDRESS BELAIR MD		25a. DATE REC'D. BY REGISTRAR DEC 24 1979		25b. REGISTRAR'S SIGNATURE Fitzroy Melby					



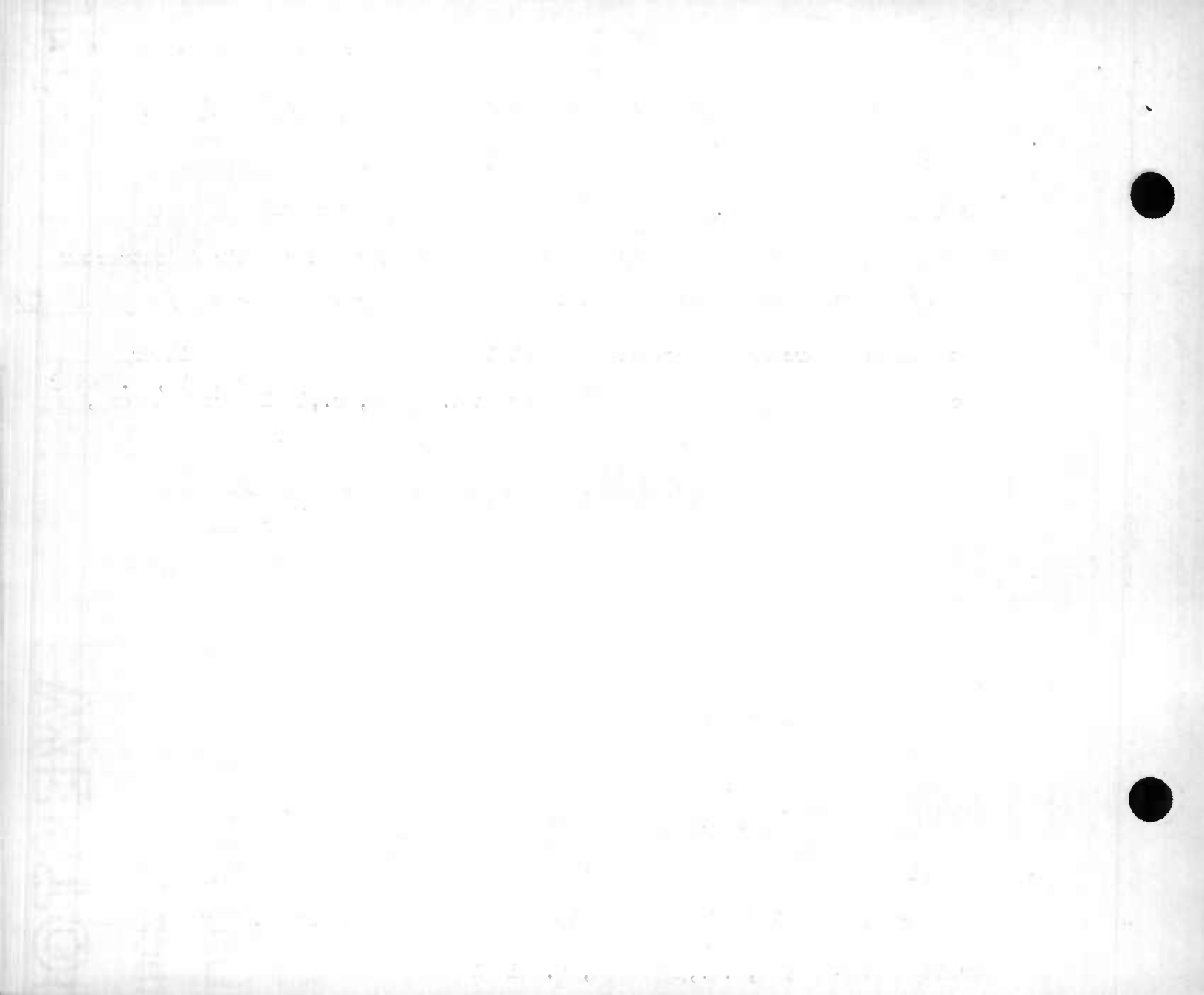
TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		7 9 3 1 0 8 2				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND DEWEY HUGHES					2a. DATE OF DEATH MONTH DAY YEAR 12-20-79			2b. HOUR 9:52 M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2 6 1899		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
12. CITY OR TOWN OF DEATH HARFORD		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (PRINT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Retired Contractor		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD.		17. CITY OR TOWN HARFORD		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS 3712 Level VILLAGE Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Stevenson Archer Hughes					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mollie Miller				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-09-2931		17. INFORMANT ADDRESS Gordon I. Hughes, Sr., 10410 Troxton Road, Adelphia, Md. 20783					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE	
22. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE Leticia S. Galvez				DEGREE M.D.				23c. DATE SIGNED	
23b. PHYSICIAN'S NAME (TYPE OR PRINT) LETICIA S. GALVEZ, M.D.				23d. ADDRESS HARFORD DE GRACE, MD.				23e. MEDICAL <input checked="" type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN PHYSICIAN	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/79		23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland		23e. DATE REC'D. BY REGISTRAR DEC 24 1979	
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001				25. DATE REC'D. BY REGISTRAR DEC 24 1979		25. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 0 8 3 REG. NO.									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR MIN.	
Virginia Estelle		Keen						Dec. 18, 1979		6:15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female		White		Oct. 11, 1913		66 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		USA				Harford MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Mem Hosp.						Housewife			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md		Cecil		Perryville				902 Frenchtown Rd			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John		Ethel		Walker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS							
No		220-14-7531		Lance W. Keen, Perryville, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mexentini occlusion</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent Ca of the colon with abscess</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>carcinoma</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>18 hours</u> <u>3 months</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>12/17</u> 19 <u>79</u> to <u>12/18</u> 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12/18</u> 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE						22c. DATE SIGNED			
<u>Mohammed</u>								12-18-79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
M.W. 18 Ave. MD		700 South Union Ave., Havre de Grace, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		12-20-79		Wesleyan Chapel Cem				Aberdeen & Harford Md.			
24. FUNERAL DIRECTOR (NAME AND ADDRESS)		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Lee A. Patterson & Son, Perryville, Md.		DEC 28 1979									

MEDICAL CERTIFICATION



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

31084

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Walter Paul KOHLMAN			2a DATE OF DEATH MONTH DAY YEAR 12-8-79			2b HOUR 3:50 AM				
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR July 7 1898		6 AGE (IN YEARS LAST BIRTHDAY) 81		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. YRS.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Louisiana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD				
10 CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON GENERAL HOSP		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lithograph Her		12b KIND OF BUSINESS OR INDUSTRY -				
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b COUNTY -		13c CITY OR TOWN Baltimore		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 4218 Stanwood Ave.	
14 FATHER'S NAME FIRST MIDDLE LAST John - Kohlman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary - Reilly			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) Yes WWI				
16b SOCIAL SECURITY NO. 215-03-3173			17 INFORMANT ADDRESS 915 Bernadette Dr Walter D. Kohlman, Forest Hill, Md.							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10/31/79 to 12/7/79 , that (I) (we) lost saw the deceased alive on 12/6/79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Joseph Reinhardt M.D., ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph REINHART						22e. ADDRESS 2003 Rockspring Rd.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/11/79		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME St. Ignace Funeral Home, Inc.					ADDRESS 331 Brehms Lane Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE Patricia Kelly	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of 56

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4, IN THE DIVISION OF VITAL RECORDS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VIR A15 ME (5))
15M 7/76

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. 31085
1. DECEASED NAME (TYPE OR PRINT) WILLIAM D LABANZ										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 5 79
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR Dec 17, 1933	6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 5 79	2b. HOUR 8:20			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County				
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) President County Fuel Co		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2015 Gumtree Terrace		
14. FATHER'S NAME FIRST MIDDLE LAST Julius Joseph LaBanz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia Dooley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes				16b. SOCIAL SECURITY NO. 213-32-4682		17. INFORMANT ADDRESS Mrs Audrey LaBanz Same				
18. CASE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF strangulation Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) strangulation DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12/5 79 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject strangled				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION 2015 Gum Tree Rd., Bel Air, Maryland				
22a. I certify that I took charge of the remains described above, held an <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Margie A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 12/6/79		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 12/10/79		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore		
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 10 1979		25b. SIGNATURE Robert M. Ruck				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 1.

BP

DHMM - 16 50M 7/77
(VR A 15 (4))

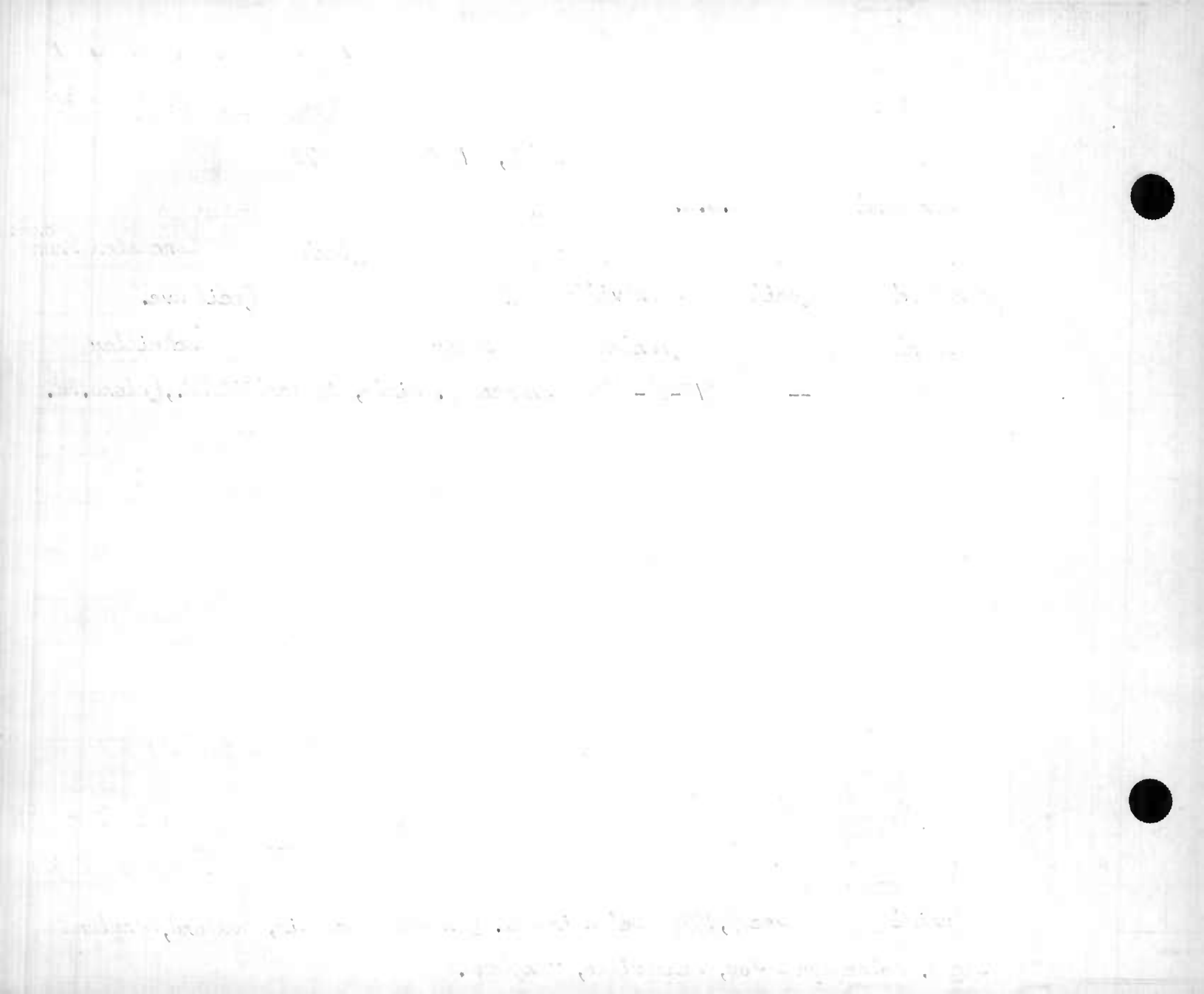
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1- FOR STATE REGISTRAR					7 9 3 1 0 8 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) PHILLIP JOSEPH LAPIERRE					2a. DATE OF DEATH MONTH DAY YEAR Dec. 25, 1979					
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR FEB. 24 1898		6. AGE (IN YEARS LAST BIRTHDAY) 81		7b. HOUR 9:00A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Hampshire		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.				
10 CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2520 Gladstone Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Wood		
13a. STATE Maryland					13b. CITY OR TOWN Bel Air		13c. STREET ADDRESS 2520 Gladstone Court			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph -- LaPierre					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 001-07-5607		17. INFORMANT ADDRESS Gary LaPierre, Bel Air, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke - Acute MI. 496- DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease + Green CHF. DUE TO, OR AS A CONSEQUENCE OF: (c) COPD.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from Dec 23, 1979 to Dec 25, 1979 that (I) (we) last saw the deceased alive on Dec 23, 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Donald W. M. Nizer MD					22c. DATE SIGNED 12/25/79			22d. ADDRESS 3009 EVERGREEN AVE		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation					23b. DATE Dec. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III					25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE John H. Brady			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					7931087 REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Frances Virginia Mann					2a. DATE OF DEATH MONTH DAY YEAR Dec. 23, 1979			2b. HOUR 2 ²⁵ P.M.	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR March 7, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7 UNDER 1 YEAR MONTHS DAYS 7 UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.			
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Lancaster Iron Works	
13a. STATE Maryland		13b. COUNTY Cecil		13c. CITY OR TOWN Perryville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Cecil Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Charles					15. MOTHER'S MAIDEN NAME FIRST MIDDLE Fanny McNeitley				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-24-2375		17 INFORMANT ADDRESS Frances J. Riale, 912 Nesbitt Rd., Coloma, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial Infarction</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>6-24-74</u> to <u>12-23-79</u> , that (I) (we) last saw the deceased alive on <u>12-23-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil Taylor					DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12-24-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Neil Taylor Jr.					22e. ADDRESS 112 WALNUT ST. Rising Sun, Md 21111				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec 27, 1979		23c. NAME OF CEMETERY OR CREMATORY Bel A in Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air Harford Maryland		
24. FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 1980				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medic examiner must be notified of once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 8 8 REG. NO.									
1. FOR STATE REGISTRAR										2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND NMIY NAHRGANG										12		29		79		9:45 PM			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
MALE			WHITE			MONTH DAY YEAR 8 21 96			83 YRS.			MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
ILLINOIS			U.S.A.						HARFORD COUNTY MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
HARVE DE GRACE			CITIZENS NURSING HOME						U.S. NAVY (30) yr.			RETIRED							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		621 BOXELDER DRIVE								
MARYLAND			HARFORD			EDGEWOOD													
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JOHN NAHRGANG										NONIE MOE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
yes										WWW 1944		038-09-1483		ROBERT E. NAHRGANG, EDGEWOOD MD 21040					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) Cardio respiratory failure																			
4589 DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)									
DUE TO, OR AS A CONSEQUENCE OF										(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
				P.M. 19															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 3-1-79, 19, to 12-30-79, 19, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE										DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
B. PAREKH MD.																			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS									
B. PAREKH MD.										622 S. Union Ave. Harve De Grace MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE									
BURIAL				2 JAN, 1980		MT. ERIN, CEM				HARVE DE GRACE, HARFORD, MD									
24. FUNERAL DIRECTOR NAME ADDRESS										25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
R. Macdonald Mitchell, HARVE DE GRACE, MD										JAN 2 1980									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

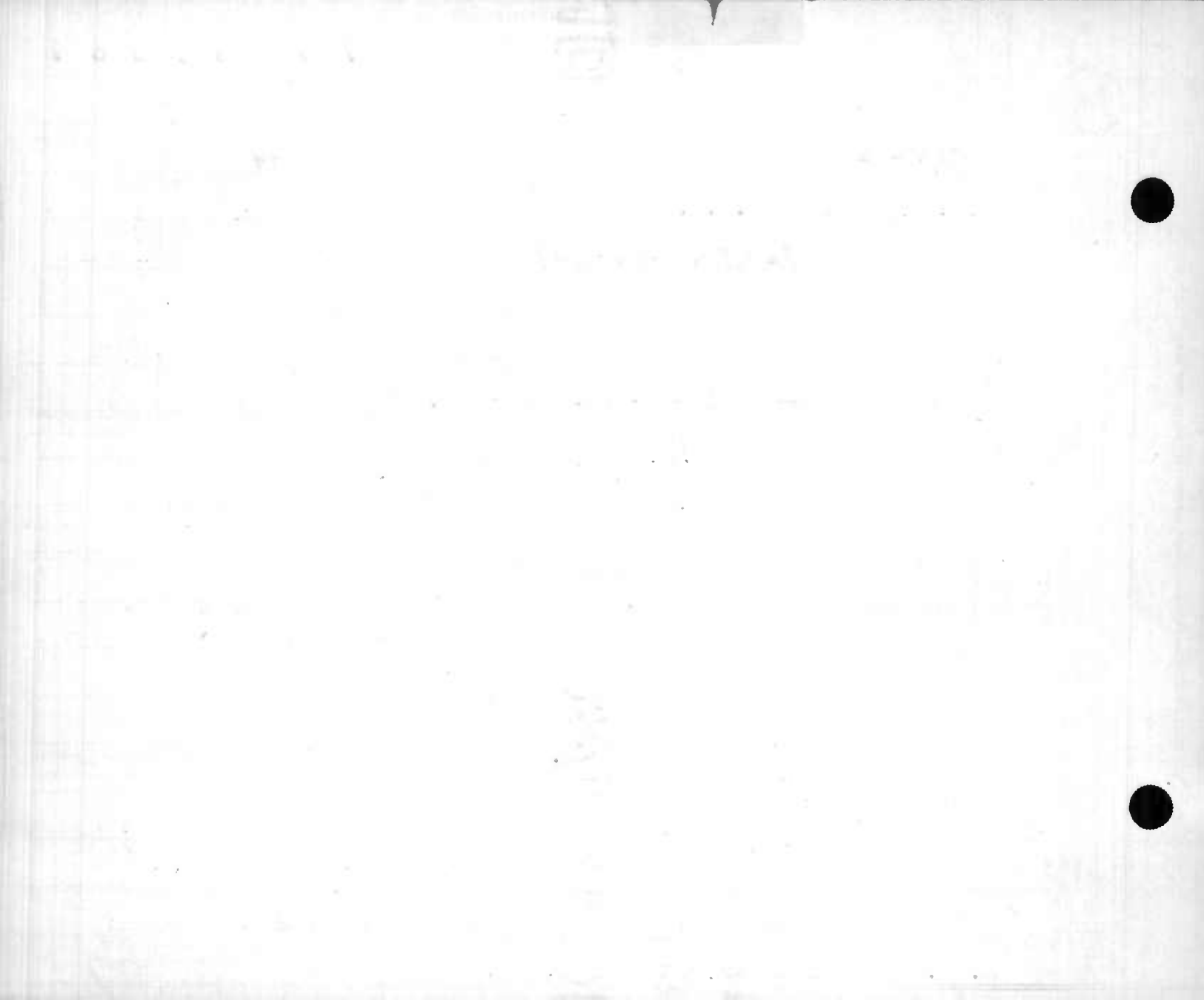
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 20M
(VRA 15, 4) 7/78

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		Annette		79		31089		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH		DAY	
HELEN A. NIXON				12 7 79		10 ⁰⁰ A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDECEASED 1 YEAR	
FEMALE		Cauc		3 1 35		44 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia		U.S.A.				Hartford MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Fallston		FALLSTON GENERAL				Clerk		Plastics	
13a. STATE				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
MD				Hartford		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3812 Belmont Drive	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST				FIRST MIDDLE LAST					
Andrew Shope				Ina Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				213-34-2720		Harry C. Nixon same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1991 Metastatic Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from September 19 79, to Dec 7 19 79, that (I) (we) lost saw the deceased alive on Dec 7 19 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)									
22b. SIGNATURE				DEGREE				22c. DATE SIGNED	
Willard P. Amoss				MD				12/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
Willard P. Amoss				2404 Pleasantville Rd, Fallston, Md 21047					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
Cremation		12/11/79		Green Mount		Baltimore, Maryland			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
M. G. Kurtz 111 Jarrettsville, Md. 21084				DEC 11 1979		[Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9		3 1 0 9 0		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Nellie		— Preston		December 21, 1979		7:15 A.M.			
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		Feb. 24, 1889		90 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				Harford Co. MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Fallston		Fallston General Hospital		Housewife		Homemaker			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
Maryland		Harford Co.		Bel Air				126 Hickory Avenue - Apt. 20	
14 FATHER'S NAME FIRST MIDDLE LAST		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					
Walter		Harward		Mary Kelly					
16b. SOCIAL SECURITY NO.		17 INFORMANT (Relationship)		ADDRESS					
212-62-5336		Mrs. Frances K. Waldenberger		237 Crocker Drive - Apt. D Bel Air, Maryland 21014					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		Cardiac Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
4149		DUE TO, OR AS A CONSEQUENCE OF (b)		Cerebrovascular accident					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c)		ASCVD, CMI					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11-7-79 to 12-21-79, that (I) (we) last saw the deceased alive on 12-20-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		12/21/79					
V. S. Nair MD		200 Melton Ave							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Dec. 24, 1979		St. Ignatius Cath. Ch. Cem.		Forest Hill, Harford Co., Maryland 21050			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Joseph William Foster		DEC 24 1979		Hofing McCreedy					
Sparksville, Md		Bel Air, Maryland 21014							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death. The low requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

BP

DHMH - 16 50M 1/76
(VR A 15 (4))

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		7 9 3 1 0 9 1 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
WALTER GAINES PUCKETT								DECEMBER 30, 1979		1:15 AM	
3 SEX		4. RACE		5 DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		CAUCASIAN		AUG. 17 1898		81 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA		U.S.A.				HARFORD MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
FALLSTON		FALLSTON General Hospital						FARMER		DAIRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		HARFORD		BELAIR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2116 ROBERTSON RD.			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME									
THOMAS J. PUCKETT		MARGARET ROBINSON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
NO		215-36-8353		ZITA H. PUCKETT, BELAIR, MD.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardio Pulmonary failure											
4538 DUE TO, OR AS A CONSEQUENCE OF (b) (1) CVA, Hypertensive ASCVD.											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c) (2) Femoral & Iliac Vein Thrombosis.										10 days.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 12-19, 1979, to 12-30, 1979, that (I) (we) lost saw the deceased alive on 12-29, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				22c. DATE SIGNED					
B. PAREKH		MD				12-30-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
B. PAREKH MD		622 S. Union Ave. Havre De Grace MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		1/2/80		DARLINGTON		DARLINGTON, HARFORD, MD.					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
JOHN H. HARKINS DELTA, PA.		JAN 4 1980				[Signature]					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 5 days after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931092 REG. NO.			
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mollie MARY Pugh						11-28-79		6:45 PM					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 10 15 80		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tenn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.							
10. CITY OR TOWN OF DEATH FALLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FALLSTON General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Mid-wife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		1646 Meadowood Court							
14. FATHER'S NAME FIRST MIDDLE LAST John Jackson						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary ROBERTSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 277-24-9153		17. INFORMANT ADDRESS GEORGE PUGH EDGWOOD MD							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Bronchopneumonia, Respiratory DUE TO, OR AS A CONSEQUENCE OF (b) Severe ASCVD - Coronary heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) Arrhythmia Bradycardia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days Several yrs years													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Chronic cholecystitis, Urinary tract infection													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 79, to Nov. 27 19 79, that (I) (we) last saw the deceased alive on Nov. 21 19 79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Albert S.C. Sun, M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11-29-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Albert S.C. Sun, M.D.						22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/4/79		23c. NAME OF CEMETERY OR CREMATORY BELAIR MEMORIAL GARDEN		23d. LOCATION CITY OR TOWN COUNTY STATE BELAIR HA MD					
24. FUNERAL DIRECTOR NAME GEORGE W TITTLE						ADDRESS 230 BALT. PIKE BELAIR		25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE Bridget McCreedy			

SALES TAX

RECEIVED
JAN 10 1964

1	100.00	10.00	110.00
2	200.00	20.00	220.00
3	300.00	30.00	330.00
4	400.00	40.00	440.00
5	500.00	50.00	550.00
6	600.00	60.00	660.00
7	700.00	70.00	770.00
8	800.00	80.00	880.00
9	900.00	90.00	990.00
10	1000.00	100.00	1100.00

11	1100.00	110.00	1210.00
12	1200.00	120.00	1320.00
13	1300.00	130.00	1430.00
14	1400.00	140.00	1540.00
15	1500.00	150.00	1650.00
16	1600.00	160.00	1760.00
17	1700.00	170.00	1870.00
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked on item 18, please use item 18, unless any injury, or other traumatic event, the medical examiner must be notified at once.)

BP _____

DHMH - 16 50M 7/77
(VR A 15 (4))

Items 2, 3, 8 6538 12/24/79 83

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) VIRGIL G. REEVES			2a. DATE OF DEATH MONTH 12 DAY 02 YEAR 79			2b. HOUR 4:00A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 03 DAY 26 YEAR 86		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS HOURS _____ MIN _____	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE, GIVE STREET ADDRESS) CITIZENS NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER/CIVIL SERVICE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Cecil 13c. CITY OR TOWN CHESAPEAKE City			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 406 GEORGE STREET				
14. FATHER'S NAME GEORGE JOHN REEVES LAST				15. MOTHER'S MAIDEN NAME ALVA MILLER FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-20-8039		17. INFORMANT ADDRESS Alva R. Williams Edgewater, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for item 18, and/or PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Old age 797 - DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
9a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED: WHERE <input type="checkbox"/> HOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 11/24/79 to 12/2/79 , that (I) (we) last saw the deceased alive on 12/2 19 79 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death 29									
22b. SIGNATURE John D. Yun				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/4/79		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN D. YUN				22e. ADDRESS 319 UNION AVE HAVRE DE GRACE 21078					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-7-79		23c. NAME OF CEMETERY OR CREMATORY Blue Springs		23d. LOCATION CITY OR TOWN COUNTY STATE Rural Retreat Wythe Va.			
24. FUNERAL DIRECTOR NAME ROUCH'S ADDRESS NORTH EAST, MD 21901				25a. DATE REC'D. BY REGISTRAR DEC 7 1979		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-1-1	100-1-2	100-1-3	100-1-4	100-1-5	100-1-6	100-1-7	100-1-8	100-1-9	100-1-10
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100-1-41	100-1-42	100-1-43	100-1-44	100-1-45	100-1-46	100-1-47	100-1-48	100-1-49	100-1-50
100-1-51	100-1-52	100-1-53	100-1-54	100-1-55	100-1-56	100-1-57	100-1-58	100-1-59	100-1-60
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100-1-71	100-1-72	100-1-73	100-1-74	100-1-75	100-1-76	100-1-77	100-1-78	100-1-79	100-1-80
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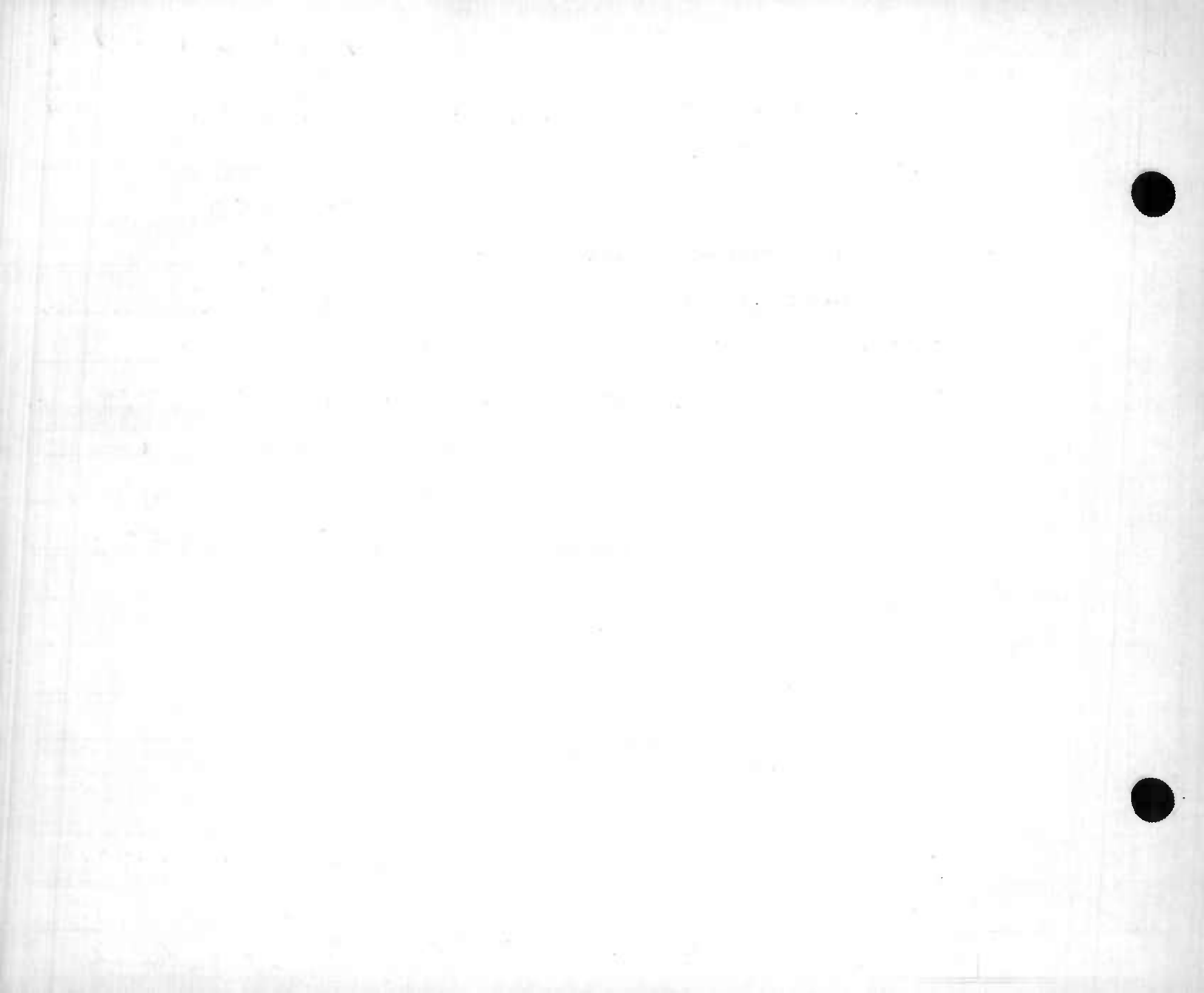
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931094	
1- FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
LAURENA FUNK Riggis						Dec. 15, 1979			4:20 AM		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Female		White		Nov. 27, 1893		86 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland		USA				HARFORD					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
HAURE de Grace		HARFORD Memorial Hosp.				Housewife		--			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS			
13a. STATE 13b. COUNTY 13c. CITY OR TOWN								1903 Philadelphia Rd			
14 FATHER'S NAME FIRST MIDDLE LAST						15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
William F. Funk						Catherine -- Hudgins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no				213-74-4099		Mrs. Kathryn R. Williams, Joppa, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>cardiac failure & pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4273 DUE TO, OR AS A CONSEQUENCE OF (b) <u>coronary infarction</u>										1 hr	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) <u>jaundice</u>										by standing 10 days	
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u></u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>79</u> , to <u></u> , 19 <u></u> , that (I) (we) lost saw the deceased alive on <u>12-15</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>M W I Hume, MD</u>						DEGREE			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howard K. McComas III</u>						ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. ADDRESS <u>700 S Union Ave Harford, Md</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			Dec. 17, 1979		Bel Air Mem. Gardens		Bel Air Harford Md.				
24 FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Howard K. McComas III, Abingdon, Md.						DEC 17 1979		<u>L. H. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 0 9 5 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Marguerite Dane Scarff				2a. DATE OF DEATH MONTH DAY YEAR December 26, 1979				2b. HOUR 10:15 ^{PM}
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 20, 1890		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Aberdeen		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1425 Old Stepney Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Monkton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST James Morris Scarff		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenny Caldwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO				
16b. SOCIAL SECURITY NO. 212-40-6634		17. INFORMANT ADDRESS William B. Richardson Bel Air, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Convulsive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HAZARD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12-15-79</u> to <u>12-26-79</u> , that (I) (we) last saw the deceased alive on <u>12-15-79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did not view the body after death.								
22b. SIGNATURE Peter P. Rodman, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-26-79		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/1979		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Fallston, Harford, Md.		
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz III		ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 31 1979		25b. REGISTRAR'S SIGNATURE [Signature]		

SECRET



SECRET

NOT TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. **NOT TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PREGOIN STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH						REG. NO. 31096	
1. DECEASED NAME (TYPE OR PRINT) Margaret D Scherer						2a. DATE KNOWN OF DEATH ESTIMATED 12 8 1979	
3. SEX F		5. DATE OF BIRTH MONTH DAY YEAR 6 10 11 68 YRS.		6. AGE (IN YEARS) LAST BIRTHDAY MONTHS DAYS HOURS MIN. 68 YRS.		2c. DATE PRONOUNCED DEAD 12 8 1979	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford Co.	
10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hos. Fallston Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	
12b. KIND OF BUSINESS OR INDUSTRY Home Keeping							
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Hydes		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 12508 Regwood Rd							
14. FATHER'S NAME FIRST MIDDLE LAST Adorph Reidel				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Otille Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 213-52-1156		17. INFORMANT ADDRESS Hydes, Md. 21082 Mr. Roland A. Scherer, 12508 Regwood Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest; ASHD 1952 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Probable Carcinoma, Abdominal (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>.							
ACTUAL SIGNATURE Willard P Amoss		TITLE (SPECIFY) Asst Dir		M.D. MEDICAL EXAMINER		DATE SIGNED 12/9/79	
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss		ADDRESS 2404 Pleasantville Rd, Fallston Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-12-1979		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS E.F. Lassahn, 11750 Belair Rd., Kingsville, Md. 21087				25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

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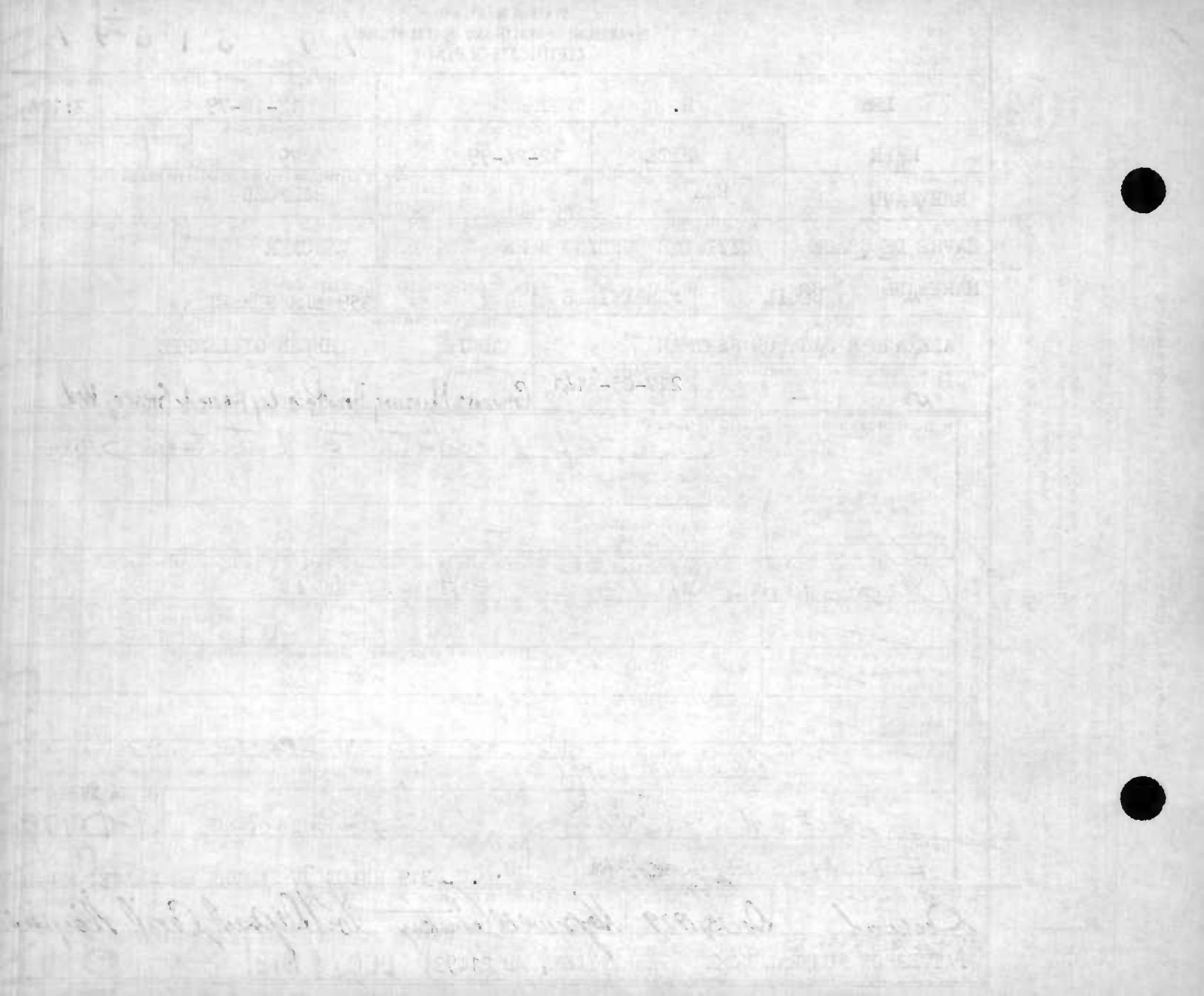
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 7 9 3 1 0 9 7			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LEE H. SENTMAN				12-10-79			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12-24-99		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.	
10. CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZENS NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND 13a. CITY OR TOWN CECIL PERRYVILLE				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 359 ELM STREET	
14. FATHER'S NAME FIRST MIDDLE LAST ALEXANDER JACKSON SENTMAN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE HELEN GILLESPIE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 217-05-4141		17. INFORMANT ADDRESS Citizens Nursing Home Records, Havre de Grace, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Ca. of prostate c metastasis</u> 185- DUE TO, OR AS A CONSEQUENCE OF (b) <u>-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Chronic Brain Syndrome & A.S. C.V.D.</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE-FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov. 23, 1979</u> to <u>Dec. 10, 1979</u> , that (I) (we) lost saw the deceased alive on <u>Dec. 10, 1979</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Edward C. Loo, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/10/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS U.M.C., 319 UNION AVE HAVRE DE GRACE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Dec 13, 1979		23c. NAME OF CEMETERY OR CREMATORY Harpwell Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Perryville Cecil Maryland	
24. FUNERAL DIRECTOR PATTERSON FUNERAL HOME				25. DATE REC'D. BY REGISTRAR (TYPE OR PRINT) DEC 13 1979			



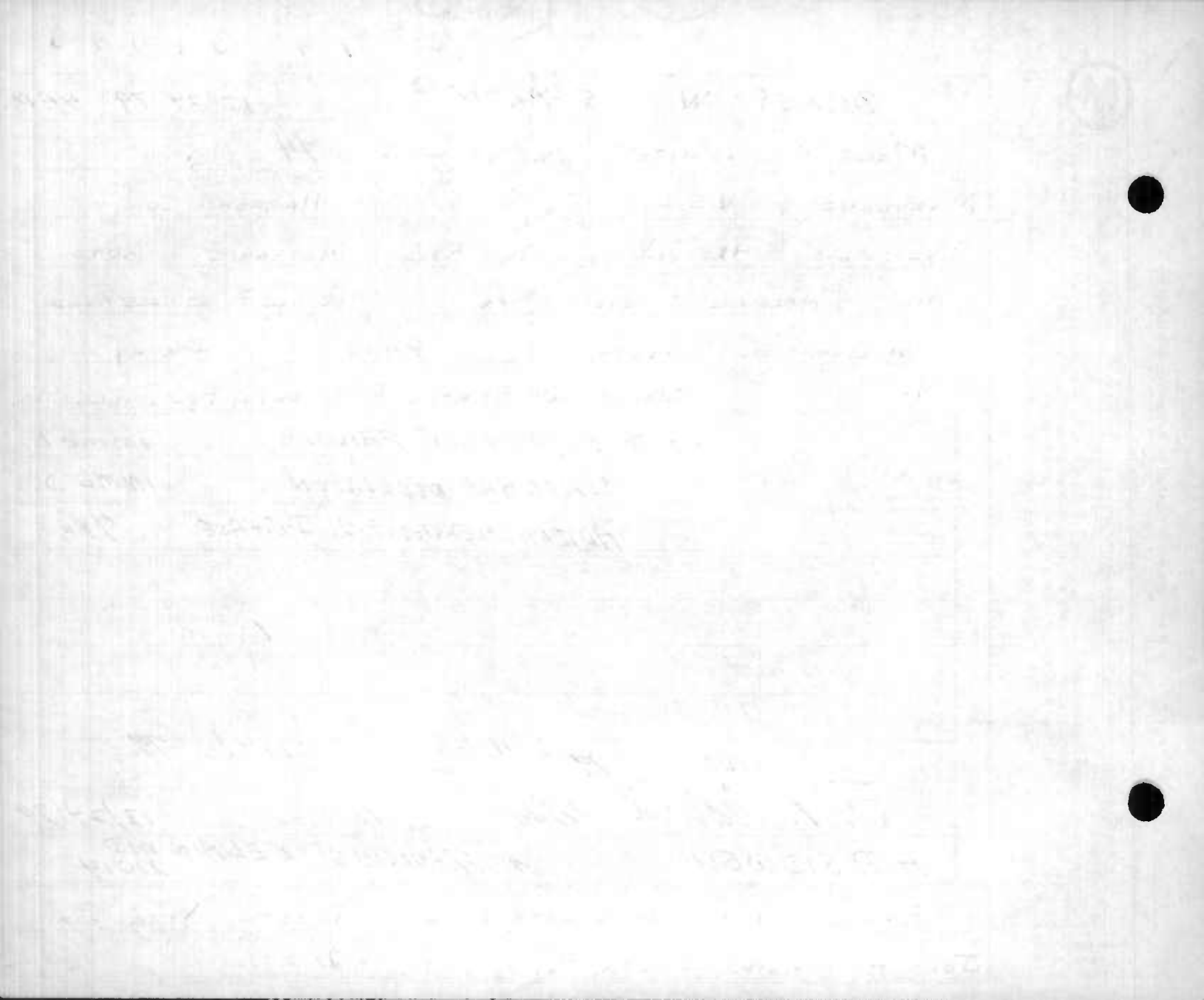


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 0 9 8	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST DERMER		MIDDLE W.		LAST SHARON		2a. DATE OF DEATH MONTH DAY YEAR 12 24 79		2b. HOUR 4 A.M.	
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JUNE 23 1905		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD CO. MD.					
10 CITY OR TOWN OF DEATH PYLESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 913 OLD PYLESVILLE ROAD						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC		12b. KIND OF BUSINESS OR INDUSTRY AUTO	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN PYLESVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 913 OLD PYLESVILLE ROAD			
14 FATHER'S NAME FIRST MIDDLE LAST WILLIAM S. SHARON				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA DRURY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-03-0667		17 INFORMANT ADDRESS BERTHA R. SHARON, PYLESVILLE, MD.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CARDIO-RESP. FAILURE 410- } DUE TO, OR AS A CONSEQUENCE OF CORONARY OCCLUSION (b) } DUE TO, OR AS A CONSEQUENCE OF ARTERIO-SCLEROTIC C.V. DISEASE (c) } CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED. IMMED. 7 YRS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2/11/65 to 12/24/79 that (I) (we) last saw the deceased alive on 11 Dec 79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.											
22b. SIGNATURE H. P. Sidwell M.D.										22c. DATE SIGNED 12/24/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. P. SIDWELL										22e. ADDRESS 401 FRANKLIN ST. BEL AIR, MD 21014	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-27-79		23c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		23d. LOCATION CITY OR TOWN COUNTY STATE DELTA YORK PA.		24. FUNERAL DIRECTOR NAME ADDRESS JOHN H. HARKINS, DELTA, PA.			
25a. DATE REC'D. BY REGISTRAR JAN 2 1980						25b. REGISTRAR'S SIGNATURE H. P. Sidwell					

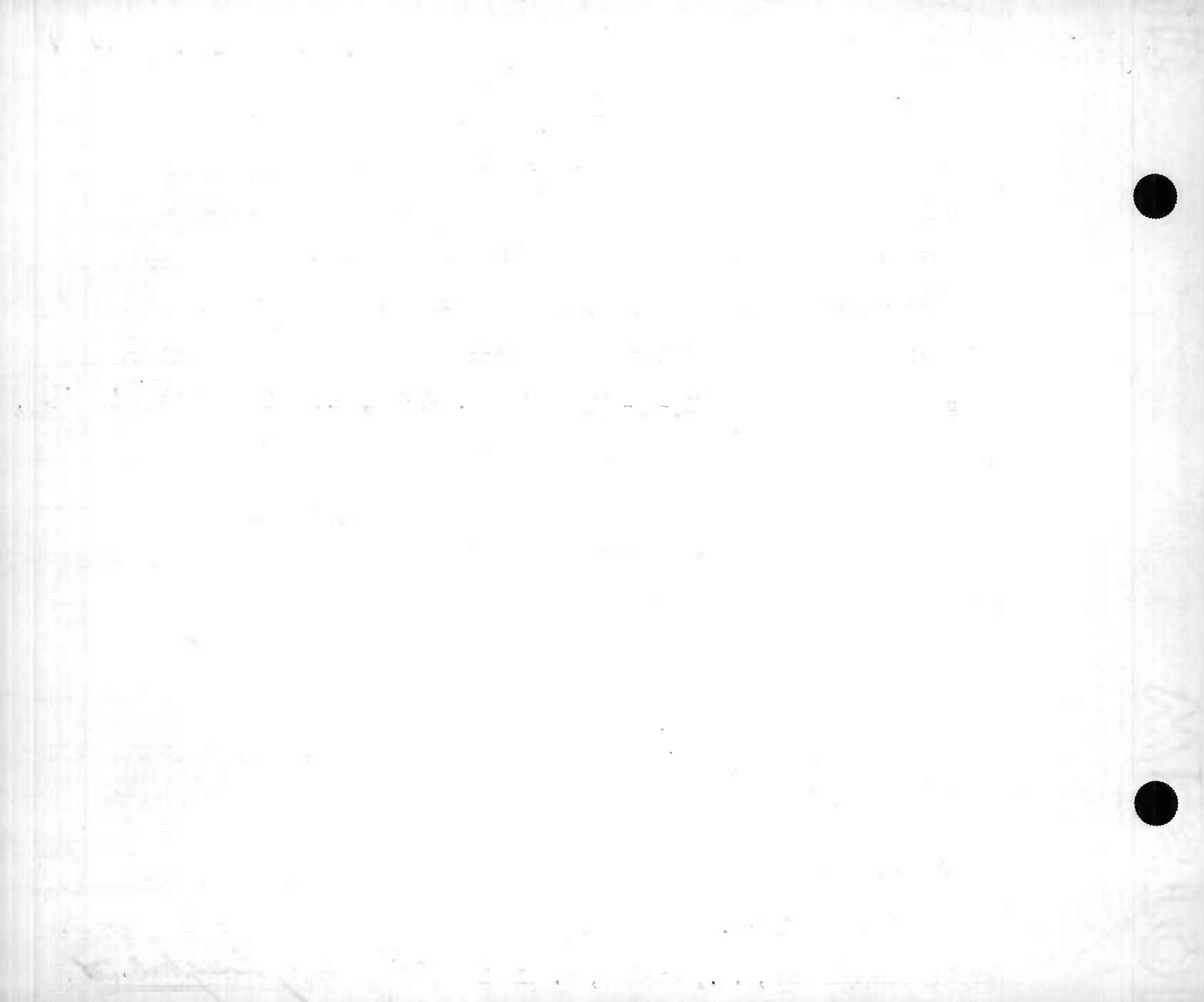


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		7 9 3 1 0 9 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) James Henry Shipley, SR.		2a. DATE OF DEATH MONTH DAY YEAR Dec. 29 1979		2b. HOUR 9:30 AM	
3. SEX male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 4 5 1909		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.	
10. CITY OR TOWN OF DEATH Harford	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farm
13a. COUNTY Md		13b. CITY OR TOWN Harford		13c. STREET ADDRESS 2421 Old Robin Hood Rd	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Shipley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Bartlett		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 211-03-7513		17. INFORMANT James H. Shipley, Jr., 2421 Old Robin Hood Road, Harford de Grace, Md. 21078			
11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> 410- DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute ANTEROSEPTAL MYOCARDIAL INFARCT</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SEVERE ARTERIOSCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>79</u> , to <u>12/29</u> , 19 <u>79</u> , that (I) (we) lost saw the deceased alive on <u>12-29</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
27b. SIGNATURE <u>B PAREKH</u>		DEGREE B PAREKH MD.		22c. DATE SIGNED 12-29-79	
27d. PHYSICIAN'S NAME (TYPE OR PRINT) B PAREKH MD		27e. ADDRESS 50 Union Ave Harford de Grace, Md 21078		27f. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1 Jan. 1980		23c. NAME OF CEMETERY OR CREMATORY Bakers Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Maryland		23e. DATE REC'D. BY REGISTRAR JAN 3 1980			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 7 9 3 1 1 0 0							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gordon R SLONAKER					2a. DATE OF DEATH MONTH DAY YEAR December 1, 1979		2b. HOUR 5:12 pm		
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR Feb. 6, 1927		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 52		IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Hartford Co. MD.			
10. CITY OR TOWN OF DEATH Perry Point, MD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VA Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) en. Laborer		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1412 W. Lombard St.	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Ray Slonaker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lottie Hott				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WWII		16b. SOCIAL SECURITY NO. 216 22 7292		17. INFORMANT ADDRESS Helen S. Fresh, 212 W. elsh Hill, Frostburg, Md.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Lymphoma 2028 DUE TO, OR AS A CONSEQUENCE OF (b) Marked Abdominal Ascites Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-6-74 , 19____, to 12-1-79 , 19____, that XXXXXX above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Coudon, M. D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH COUDON, MD					22e. ADDRESS VA Medical Center Perry Point, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/15/79		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE West Virginia			
24. FUNERAL DIRECTOR John J. Hafer, Chapel of the Hills Mortuary					25a. DATE REC'D. BY REGISTRAR DEC 6 1979		25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i>		

MEDICAL CERTIFICATION

4



1902 BP

John A. Baker, Chief of the Staff, University

Level 10

West Virginia

VA Medical Center, Perry Point, MD

9-6-76

12-1-76

General Abdominal Section

Neurological Laboratory

10/11

10/11 12/11

10/11 12/11

10/11 12/11

10/11 12/11

Perry Point, MD VA Medical Center

10/11 12/11

10/11 12/11

10/11

December 1, 1976

10/11 12/11

10/11 12/11

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

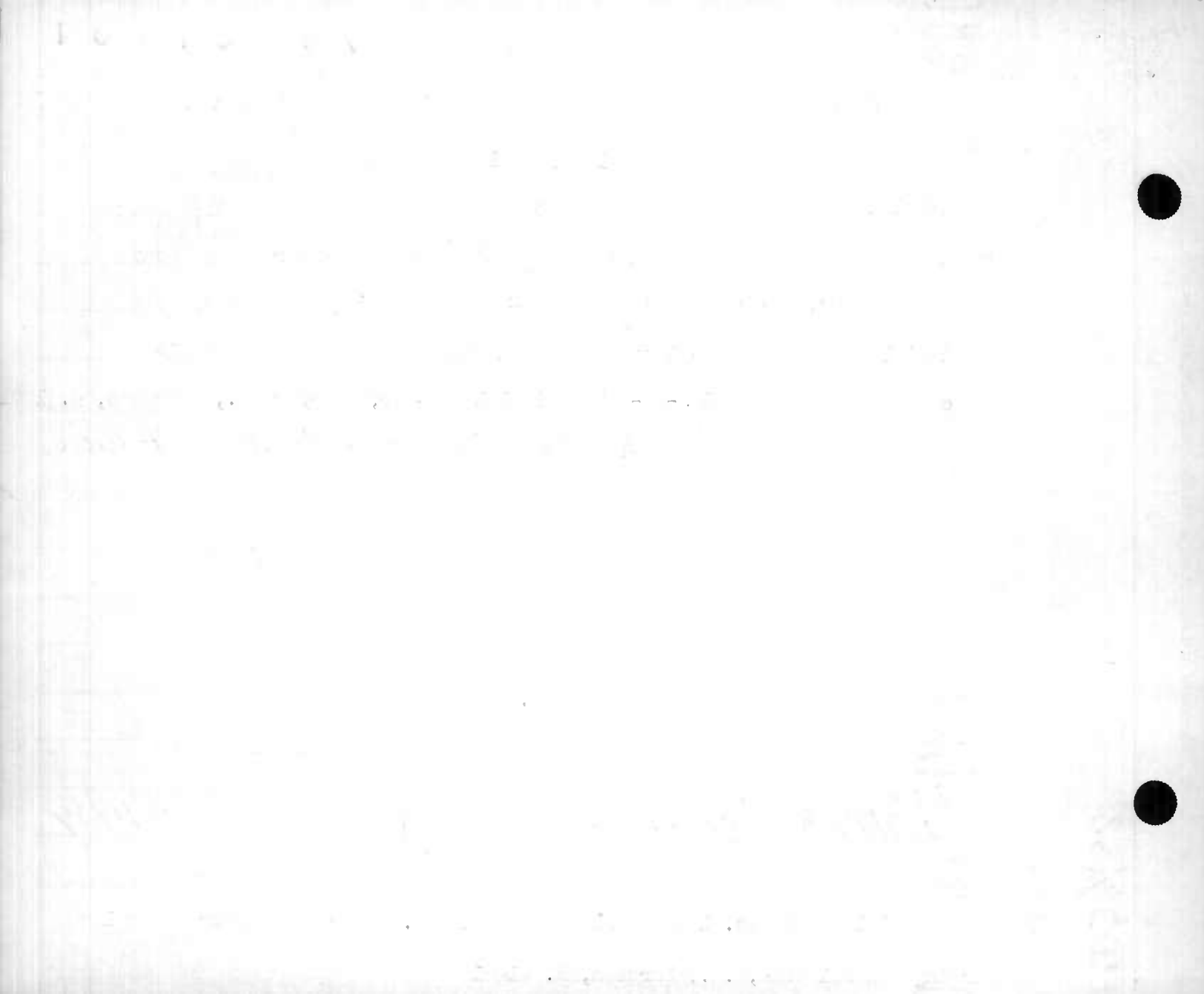
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

MEDICAL CERTIFICATION

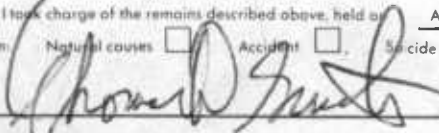

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7931101 REG. NO.			
1- FOR STATE REGISTRAR						2a. DATE OF DEATH				MONTH DAY YEAR		2b. HOUR	
1 DECEASED NAME (TYPE OR PRINT)						MAUDE E. STANDIFORD				Dec. 2, 1979		2 AM	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR		IF UNDER 24 HRS			
FEMALE		WHITE		3 30 1894		85		MONTHS		DAYS		HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		USA				HARFORD MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
HAURE de Grace		HARFORD Memorial Hospital				Homemaker		Home					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Md.		HARFORD		Aberdeen		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		29 Moyer Dr.					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Winfield Bayless				Louise Cole									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17 INFORMANT ADDRESS					
No				162-50-0729				Winfield Cooper, 29 Moyer Dr., Aberdeen, Md. 21001					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Cerebro-vascular Hemorrhage</u>													
431- DUE TO, OR AS A CONSEQUENCE OF													
(b) _____													
DUE TO, OR AS A CONSEQUENCE OF													
(c) _____													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION					
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-2</u> , 19 <u>79</u> , to <u>12-2</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>12-2</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				22c. DATE SIGNED					
IRVING WACHSMAN								12/2/79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS				22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
IRVING WACHSMAN				HAURE de Grace Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		4 Dec. 1979		Wesleyan Chapel Cem.		Aberdeen Harford						Maryland	
24 FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Tarring Funeral Home, P.A., Aberdeen, Md. 21001						DEC 5 1979		L. H. H. H.					

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 31102			
1- STATE REGISTRAR						2a. DATE KNOWN OF DEATH ESTIMATED						MONTH DAY YEAR		7b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jerry Alan Stauffer						2c. DATE PRONOUNCED DEAD						MONTH DAY YEAR		2d. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN		IF UNDER 1 YR.		IF UNDER 24 HRS.		2e. DATE PRONOUNCED DEAD		2f. HOUR	
Male		White		August 3, 1962		17 YRS.						12 21 1979		5:15A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland				USA								Harford County MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Havre de Grace				Parallel to Rt#40 behind Exxon Sta.				Laborer				Sod Farm			
13a. STATE						13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS			
Maryland						Harford		Darlington				2500 Shuresville Road			
14. FATHER'S NAME FIRST MIDDLE LAST						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
James R. Stauffer Sr.						Colleen Gehman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)						16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS							
No						213-80-0529		James R. Stauffer, Sr.; Darlington, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Stab wounds of neck</u> 966 - Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				? P.M. 12 21 19 79				subject assaulted							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
				unknown				unknown							
22a. I certify that I took charge of the remains described above, held in death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
				M.D. Deputy Chief				MEDICAL EXAMINER				12/22/79			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				111 Penn St.				Baltimore, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial				Dec. 24, 1979		Darlington				Darlington Harford Maryland					
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR						25b. REGISTRAR'S SIGNATURE			
John H. Harkins, 600 Main Street, Delta, Penna.						DEC 27 1979									

MEDICAL CERTIFICATION

3010

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

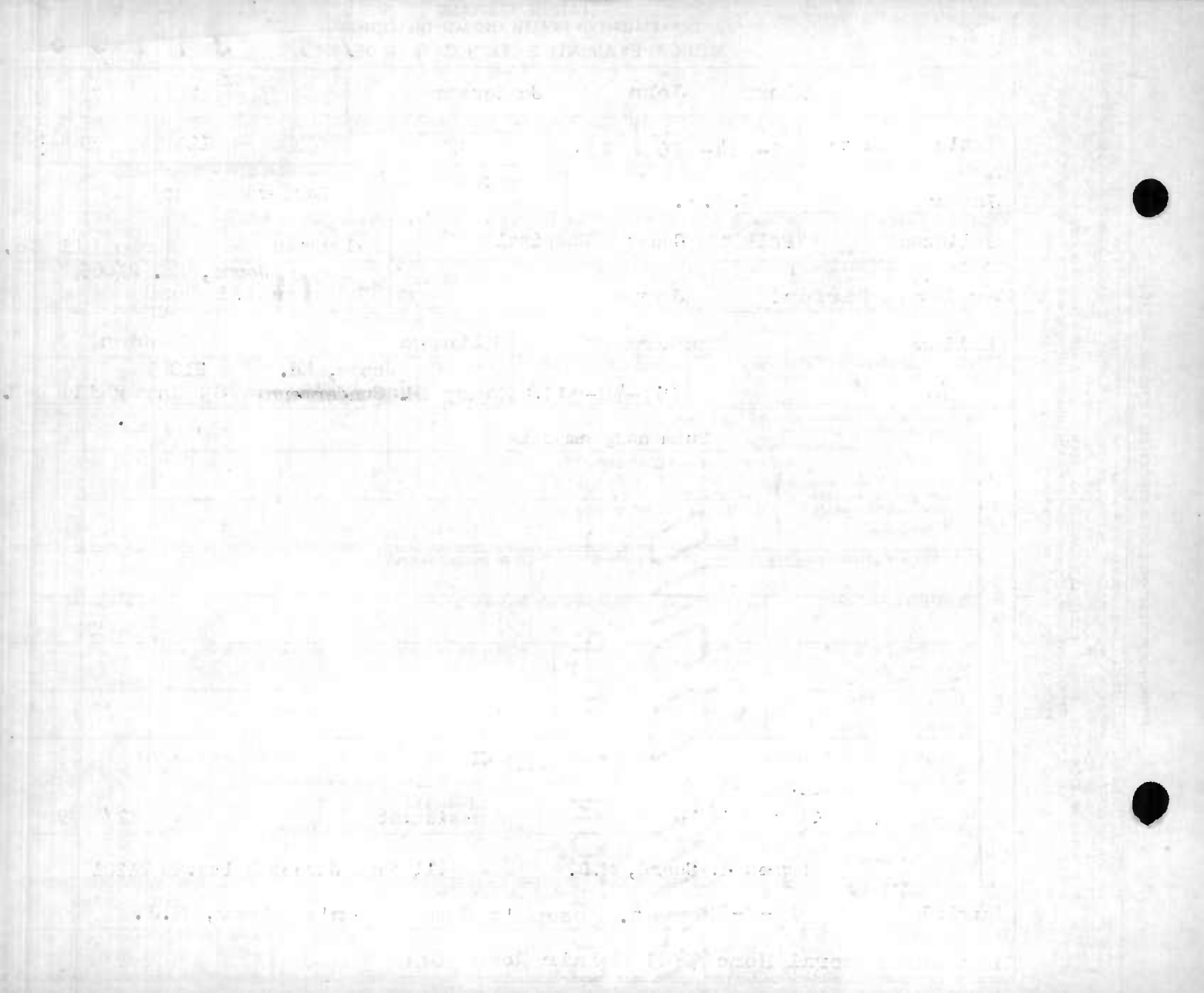
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
UNITED STATES DEPARTMENT OF AGRICULTURE

[Faint handwritten signature or text]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
REG. NO. 31103									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		20. DATE KNOWN OF DEATH	
Robert		John		Sundermann				20. DATE KNOWN OF DEATH	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.	
male		white		5-14-50		29 YRS.		7. IF UNDER 24 HRS.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED		11. NEVER MARRIED		12. DATE PRONOUNCED DEAD	
Japan		U.S.A.		WIDOWED		DIVORCED		12. DATE PRONOUNCED DEAD	
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY		17. BALTIMORE CITY OR COUNTY OF DEATH	
Fallston		Fallston General Hospital		Salesman		Fram Oil Co.		Harford County	
18. USUAL RESIDENCE (IF IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. STATE		20. COUNTY		21. CITY OR TOWN		22. INSIDE CITY LIMITS?	
Maryland		Harford		Joppa		Joppa, Md. 21085		YES NO	
23. FATHER'S NAME		24. MOTHER'S MAIDEN NAME		25. STREET ADDRESS		26. ADDRESS		27. ADDRESS	
William		Elinore		83 Haverhill Road		Joppa, Md. 21085		83 Haverhill Rd.	
28. WAS DECEASED EVER IN U.S. ARMED FORCES?		29. SOCIAL SECURITY NO.		30. INFORMANT		31. ADDRESS		32. ADDRESS	
No		157-40-9118		Nancy M. Sundermann		Joppa, Md. 21085		83 Haverhill Rd.	
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								34. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Pulmonary embolism									
4/5/19									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
35. DATE OF OPERATION		36. CONDITION FOR WHICH OPERATION WAS PERFORMED?				37. AUTOPSY?			
						YES NO			
38. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		39. TIME OF INJURY		40. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
41. INJURY OCCURRED WHILE AT WORK		42. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		43. LOCATION		CITY OR TOWN		COUNTY STATE	
AT WORK				STREET					
44. I certify that I took charge of the remains described above, held on death resulted from									
Autopsy Inspection Inquiry and in my opinion									
Natural causes Accident Suicide Homicide Undetermined manner									
45. ACTUAL SIGNATURE		46. TITLE (SPECIFY)				47. DATE SIGNED		48. DATE SIGNED	
Hormez R. Guard, M.D.		Assistant				12/5/79		12/5/79	
49. EXAMINER'S NAME (TYPE OR PRINT)		50. ADDRESS		51. ADDRESS		52. ADDRESS		53. ADDRESS	
Hormez R. Guard, M.D.		111 Penn Street, Balto. MD 21201							
54. BURIAL, CREMATION, REMOVAL		55. DATE		56. NAME OF CEMETERY OR CREMATORY		57. LOCATION		58. STATE	
Burial		12-8-79		St. Joseph's Cem		Tom's River, N.J.			
59. FUNERAL DIRECTOR		60. DATE REC'D. BY REGISTRAR		61. REGISTRAR'S SIGNATURE		62. REGISTRAR'S SIGNATURE		63. REGISTRAR'S SIGNATURE	
Lassahn Funeral Home		DEC 11 1979		Hormez R. Guard		Hormez R. Guard		Hormez R. Guard	
NAME		ADDRESS		ADDRESS		ADDRESS		ADDRESS	
Lassahn Funeral Home		7401 Belair Road							



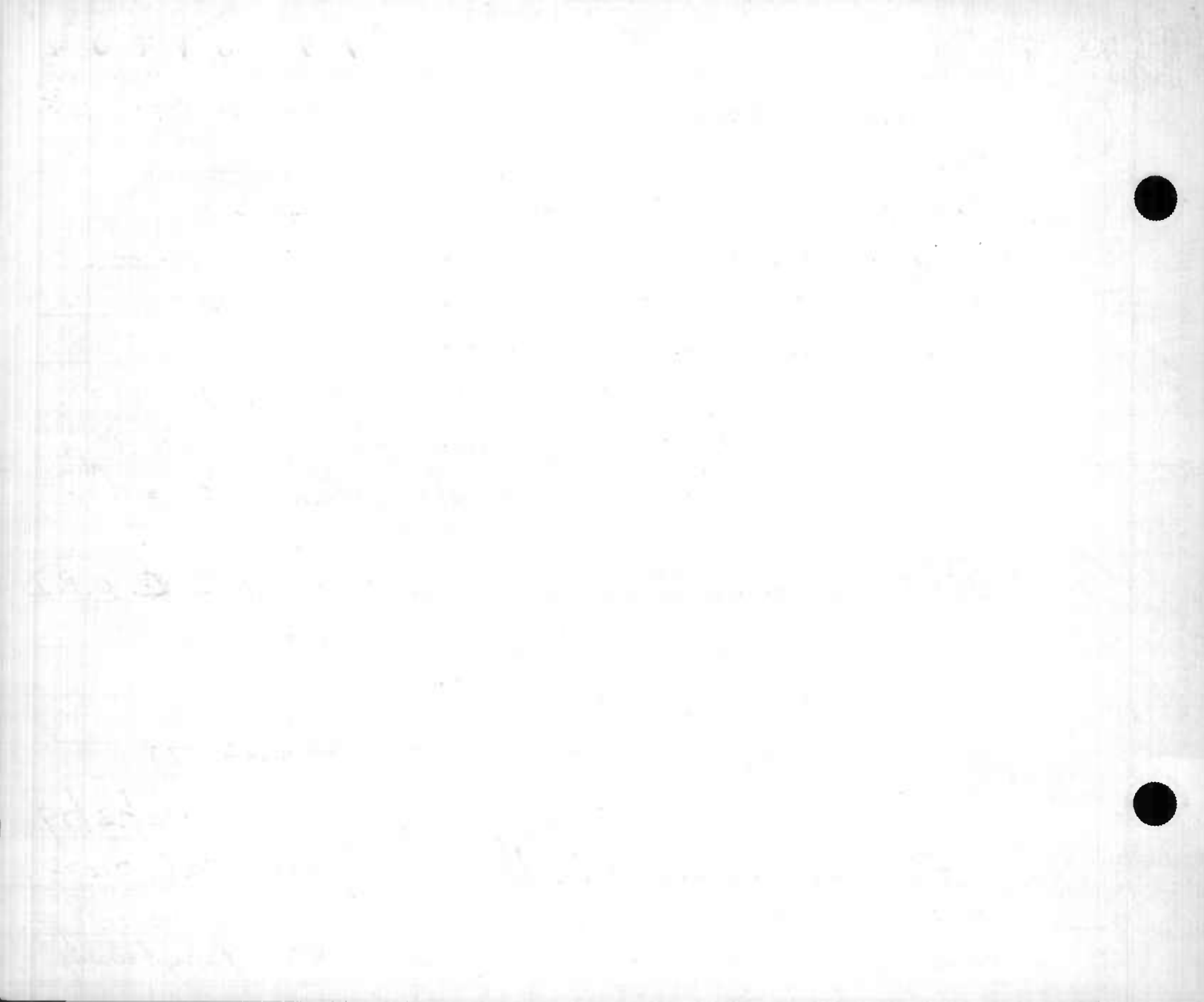
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										7 9 3 1 1 0 4 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Meril Leroy Tasco Sr.						2a. DATE OF DEATH MONTH DAY YEAR Dec. 23 1979				2b. HOUR 10 PM			
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Dec. 12, 1896		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS		8 IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford MD.							
10 CITY OR TOWN OF DEATH Havre de Grace		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian		12b. KIND OF BUSINESS OR INDUSTRY US-govt.					
13a. STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Darlington		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2212 Glen Cove Road					
14 FATHER'S NAME FIRST MIDDLE LAST Harry -- Tasco, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth -- Tasco									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO 219-01-1504A		17 INFORMANT ADDRESS Adelaide E. Tasco, Darlington, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Bilateral Pneumonia 4392 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac Decompensation due to DUE TO, OR AS A CONSEQUENCE OF (c) A.S.C.V.D. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 days 2 days ?													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (a) Chronic Brain Syndrome due to Senility (2) C.O.P.D.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Dec. 12, 1979 to Dec. 23, 1979, that (I) (we) last saw the deceased alive on Dec. 23, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Edward C. Loo, M.D.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD C. LOO, M.D.				22e. ADDRESS Havre de Grace, Md. 21078.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 26, 1979		23c. NAME OF CEMETERY OR CREMATORY Berkley Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Darlington Harford Md.							
24 FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md.						25a. DATE REC'D. BY REGISTRAR DEC 27 1979		25b. REGISTRAR'S SIGNATURE L. H. H. H.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 1 0 5 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Roy TURNER						2a. DATE OF DEATH MONTH DAY YEAR 12 14 79		2b. HOUR 3:50 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-17-1897		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD			
10. CITY OR TOWN OF DEATH FANLSTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FANLSTON GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Farming	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Harford		13c. CITY OR TOWN White Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4315 Harford Creamery Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST James Leslie Turner					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nancy H. Miskimon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-36-7937		17. INFORMANT ADDRESS Juliet A. Turner same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275- IMMEDIATE CAUSE (a) CARDIOVASCULAR ARREST DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Joseph Rankell				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12/14/1979	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH RANKELL				22e. ADDRESS 2003 Rock Spring Rd.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/16/1979		23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION CITY OR TOWN COUNTY STATE Madonna, Harford, Md.			
24. FUNERAL DIRECTOR NAME M. G. Kurtz III				ADDRESS Jarrettsville, Md.		25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that this is crucial for ensuring the integrity of the financial data and for providing a clear audit trail.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in entering data into the system, from initial entry to final review and approval.

3. The third part of the document addresses the issue of data security. It discusses the various measures that have been implemented to protect the information from unauthorized access and to ensure its confidentiality.

4. The fourth part of the document provides a summary of the key findings and conclusions. It highlights the areas where improvements have been made and identifies the next steps for ongoing monitoring and evaluation.

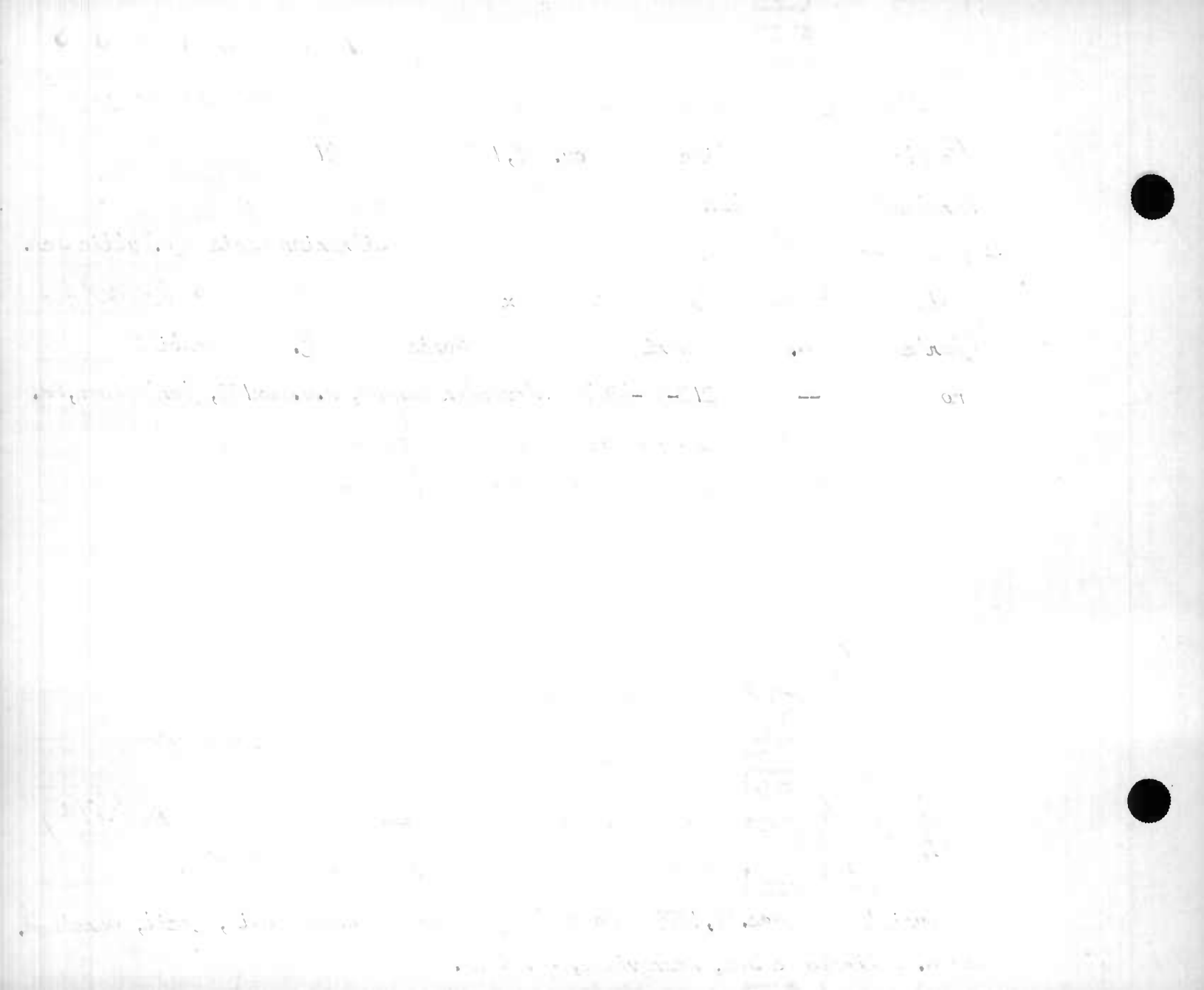
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				7 9 3 1 1 0 6 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SHIRLEY ANN VARADY			
2a. DATE OF DEATH MONTH DAY YEAR 12-27-79		2b. HOUR P M 2:15 P		3 SEX Female		4 RACE White	
5 DATE OF BIRTH MONTH DAY YEAR Nov. 21, 1938		6 AGE (IN YEARS LAST BIRTHDAY) 41 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA	
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.		10 CITY OR TOWN OF DEATH HARFORD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian Assis.		12b. KIND OF BUSINESS OR INDUSTRY Public Sch.		13a. STATE Md.		13b. COUNTY CECIL	
13c. CITY OR TOWN CHARLESTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 153 (BLACK Ave.)		14. FATHER'S NAME FIRST MIDDLE LAST Charles A. Hart	
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris C. Nesbitt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 212-38-4364		17 INFORMANT ADDRESS Alexander Varady, P.O. Box 153, Charlestown, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 430- DUE TO, OR AS A CONSEQUENCE OF (b) post, overexertion DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-20-79 to 12-27-79, that (I) (we) last saw the deceased alive on 12-27-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE R. de los Santos MD				22c. DATE SIGNED 12/28/79		22d. ATTENDING PHYSICIAN MEDICAL <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PATIENT'S NAME (TYPE OR PRINT) R. de los Santos				22f. ADDRESS Chesapeake, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Dec. 29, 1979		23c. NAME OF CEMETERY OR CREMATORY Hopewell Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Port Deposit, Cecil, Maryland.	
24 FUNERAL DIRECTOR NAME Lee A. Patterson & Son, Perryville, Maryland. ADDRESS				25a. DATE REC'D. BY REGISTRAR JAN 1 1980		25b. REGISTRAR'S SIGNATURE Hopewell	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7 9 3 1 1 0 7 REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILEY DEEMAR WALDROP					2a. DATE OF DEATH MONTH DAY YEAR 12-6-79			2b. HOUR MIN 11:25 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 13 1918		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD MD.			
10. CITY OR TOWN OF DEATH HARVEY DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HARFORD MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) TRUCK DRIVER		12b. KIND OF BUSINESS OR INDUSTRY MOVING	
13a. STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN ABERDEEN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 335 SOUTH DEEN ST	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN W WALDROP					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (UNKNOWN)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT L.E. WALDROP		ADDRESS 335 S. DEEN ST. ABERDEEN, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A.S. C.V. D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF 2 days 2 years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Stroke									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 12-4 1979, to 12-6 1979, that (I) (we) last saw the deceased alive on 12-6 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edward C. Loo, M.D.		DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edward C. Loo, M.D.		22e. ADDRESS Harvey de Grace, Md. 21078							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-10-79		23c. NAME OF CEMETERY OR CREMATORY ANGEL HILL CEM.		23d. LOCATION CITY OR TOWN COUNTY STATE HARVEY DE GRACE HARFORD MD			
24. FUNERAL DIRECTOR NAME Pennington & Son		ADDRESS Harvey de Grace, Md.		25a. DATE REC'D. BY REGISTRAR DEC 11 1979		25b. REGISTRAR'S SIGNATURE [Signature]			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

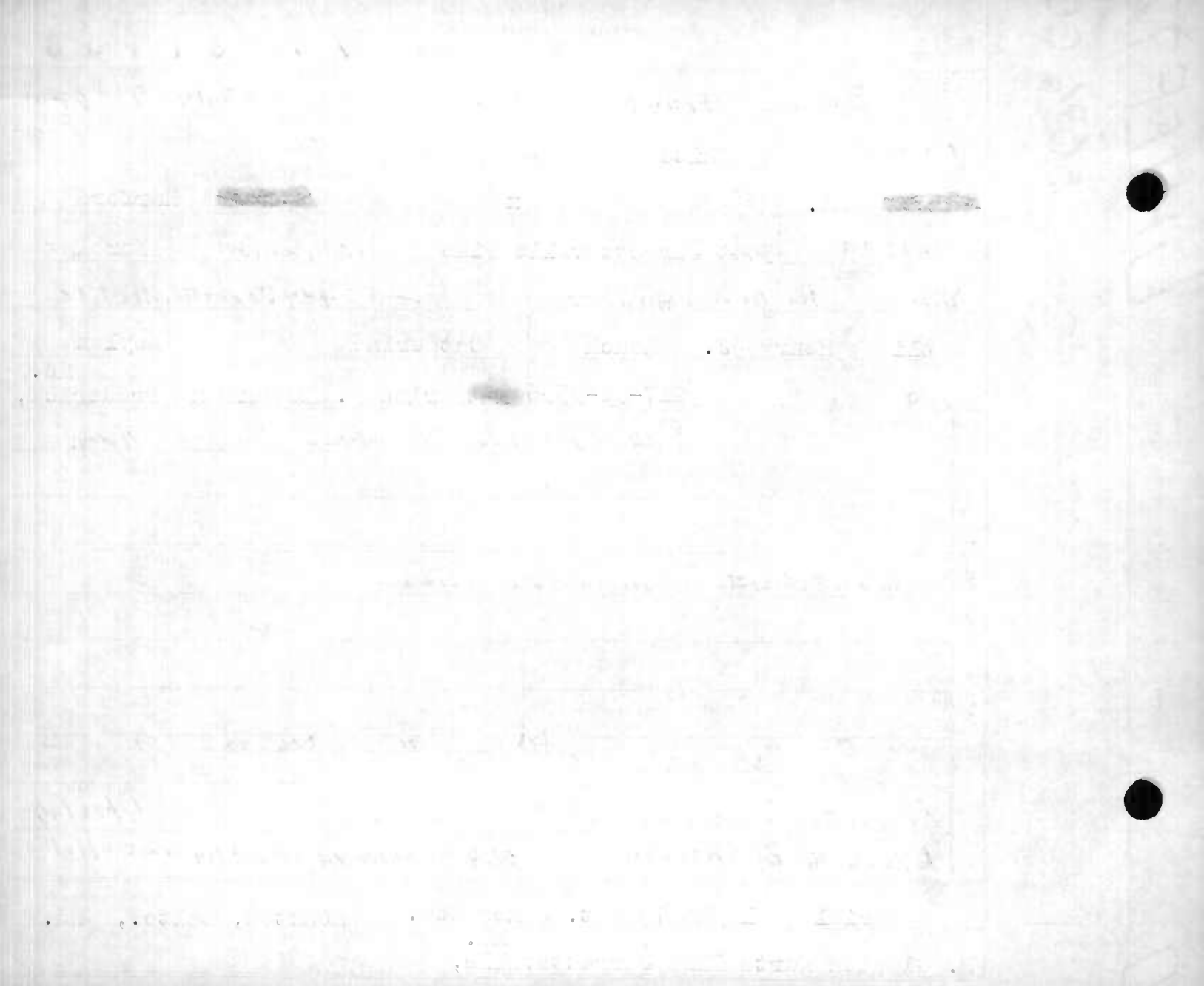
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

7 9 REG. NO. 3 1 1 0 8

1 DECEASED NAME (TYPE OR PRINT) Emma Houck Walker		2a DATE OF DEATH MONTH DAY YEAR Dec. 22, 1979		2b HOUR 6 PM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH MONTH DAY YEAR May 1 1899		6 AGE (IN YEARS LAST BIRTHDAY) 92	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Harford	
10 CITY OR TOWN OF DEATH Monkton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3444 Jarrettsville Pike		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) companion		12b. KIND OF BUSINESS OR INDUSTRY Nursing
13a. STATE Ma.	13b. COUNTY Harford	13c. CITY OR TOWN Monkton	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3444 Jarrettsville Pike	
14 FATHER'S NAME FIRST MIDDLE LAST Eli Henry J. Houck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Boylan			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 217-36-3536		17. INFORMANT ADDRESS Md. Katherine W. Zimmerman Frederick,	
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic Ischemic Cardiovascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from Dec 23 1979 to Dec 22 1979 , that (1) (we) lost saw the deceased alive on Dec 23 1979 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) did (did not) view the body after death.					
22b. SIGNATURE Elizabeth B. Sherrill M.D.		DEGREE M.D.		22c. DATE SIGNED 12/22/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Elizabeth B. Sherrill		22e. ADDRESS 2108 Monkton Rd, Monkton Md 21111			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/79		23c. NAME OF CEMETERY OR CREMATORY St. James Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Monkton, Balto., Md.		23e. DATE REC'D. BY REGISTRAR DEC 27 1979			
24. FUNERAL DIRECTOR NAME M. Gladden Kurtz III		ADDRESS Jarrettsville, Md.		25b. REGISTRAR'S SIGNATURE Anthony M. Brady	



BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING TO THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGES 4, 5, AND 6 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 7 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31109	
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST John Marshall Warner					2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 7 1979					2b. HOUR 12:30 P M						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1904			6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 7 1979			2d. HOUR 12:30 P M							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford County, MD.										
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Custodian				12b. KIND OF BUSINESS OR INDUSTRY School-SESD							
13a. STATE Penna.				13b. COUNTY York		13c. CITY OR TOWN Fawn Grove			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Morris Ave. Box 44										
14. FATHER'S NAME FIRST MIDDLE LAST Edward Warner						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Elizabeth Anderson															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 195-26-1988		17. INFORMANT ADDRESS R.T. Warner, Fawn Grove, Pa. 17321															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Fracture of left tibia DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Thrombosis of right coronary artery																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR XXX MONTH DAY YEAR 6:15 P.M. 11 25 1979				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto/auto impact													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street				21f. LOCATION STREET CITY OR TOWN COUNTY STATE U.S. Rt. #1 Conowingo Harford Md.													
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE Virginia L. Dolan MD				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER				DATE SIGNED 12/8/79									
EXAMINER'S NAME (TYPE OR PRINT) Virginia L. Dolan, M.D.				ADDRESS 111 Penn Street																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/10/79		23c. NAME OF CEMETERY OR CREMATORY Fawn Grove Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Fawn Grove, York Co., Penna.											
24. FUNERAL DIRECTOR James Stewart				ADDRESS Stewartstown, Pa.				25a. DATE REC'D. BY REGISTRAR DEC 12 1979				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>									



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TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

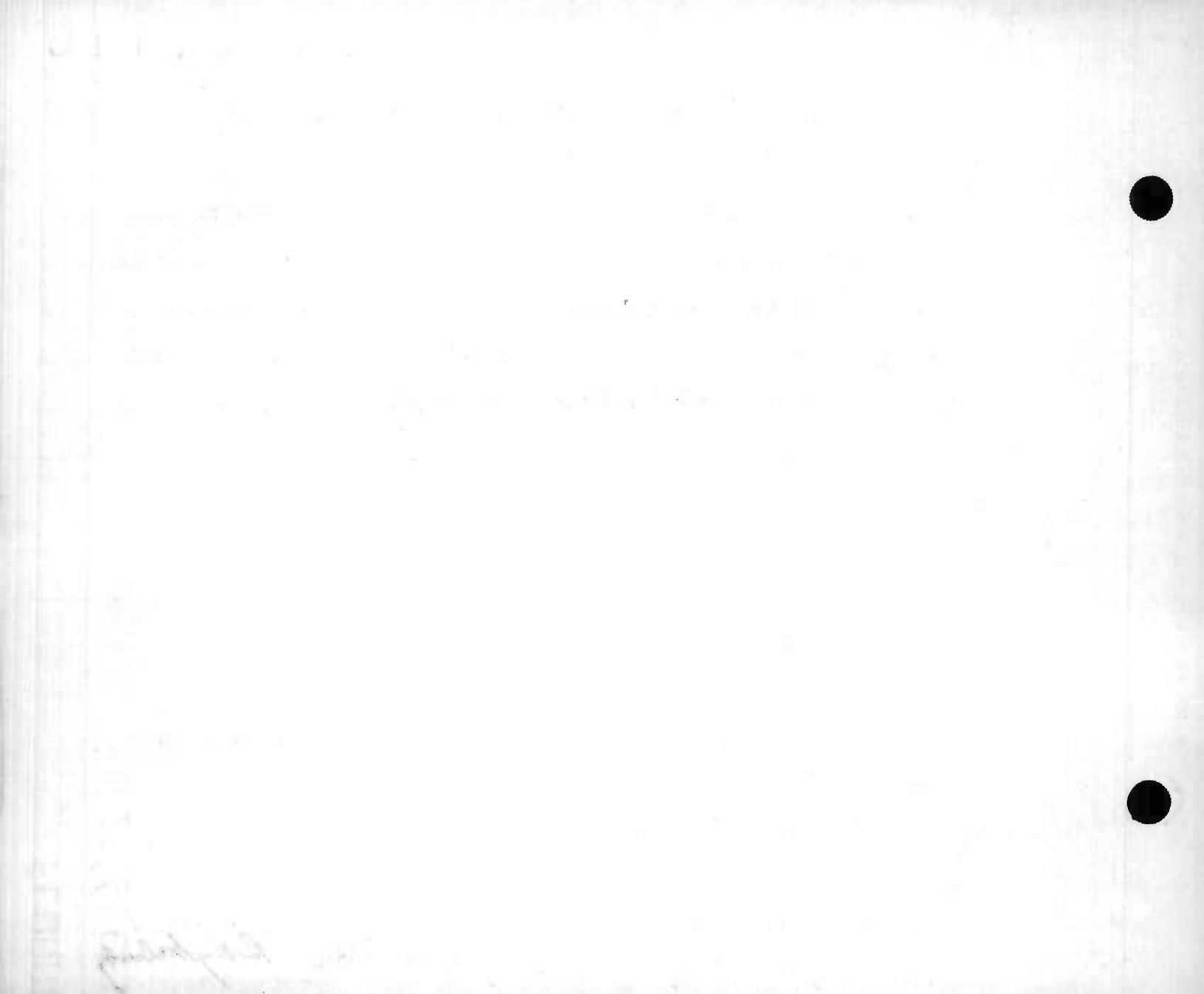
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 79 31110					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
3. SEX RACE										5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)										7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE										13b. COUNTY				13c. CITY OR TOWN	
14. FATHER'S NAME FIRST MIDDLE LAST										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. ADDRESS	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)										17b. SOCIAL SECURITY NO.				17. INFORMANT	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF (b)					
5609										Intestinal Obstruction				2 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 12-29-79 to 12-30-79, and that in my (our) opinion death occurred on the date and hour and from the causes stated															
22b. SIGNATURE										DEGREE				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE				23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE										23e. DATE REC'D. BY REGISTRAR				23f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR NAME										24b. ADDRESS				24c. DATE REC'D. BY REGISTRAR	

BP

DHMH-16 20M
(VRA 15, 4) 7/78



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 31111

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DOROTHY Snowdon Whittington		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 12 17 1979 <input type="checkbox"/> 6 PM		2b. HOUR	
3. SEX F	4. RACE Neg	5. DATE OF BIRTH MONTH DAY YEAR 9 9 11 68	6. AGE (IN YEARS) LAST BIRTHDAY YRS. MONTHS DAYS HOURS MIN.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7. IF UNDER 24 HRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DARTINGTON		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Hartford		10. CITY OR TOWN OF DEATH Fallston		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston General Hosp.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY		13a. STATE	
13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS		14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL T SNOWEN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY SNOWER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220051264		17. INFORMANT ADDRESS CHARLES Whittington DARTINGTON	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. Arteriosclerotic Heart Disease (b) } (c) }					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Diabetes Mellitus					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE Willard P. Amoss		TITLE (SPECIFY) Asst. Dep.		DATE SIGNED 12/18/79	
EXAMINER'S NAME (TYPE OR PRINT) Willard P. Amoss		ADDRESS 2404 Pleasantville Rd, Fallston, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/22/79		23c. NAME OF CEMETERY OR CREMATORY BURKLEY CEM	
23d. LOCATION CITY OR TOWN COUNTY STATE DARTINGTON HA MD		24. FUNERAL DIRECTOR NAME ADDRESS GEORGE W TITTLE BELAIR MD			
25a. DATE REC'D. BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE Dorothy Kelly			



RECEIVED
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C. 20250

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
DATE: [illegible]
[The following text is extremely faint and illegible, appearing to be a series of lines of text, possibly a letter or report.]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

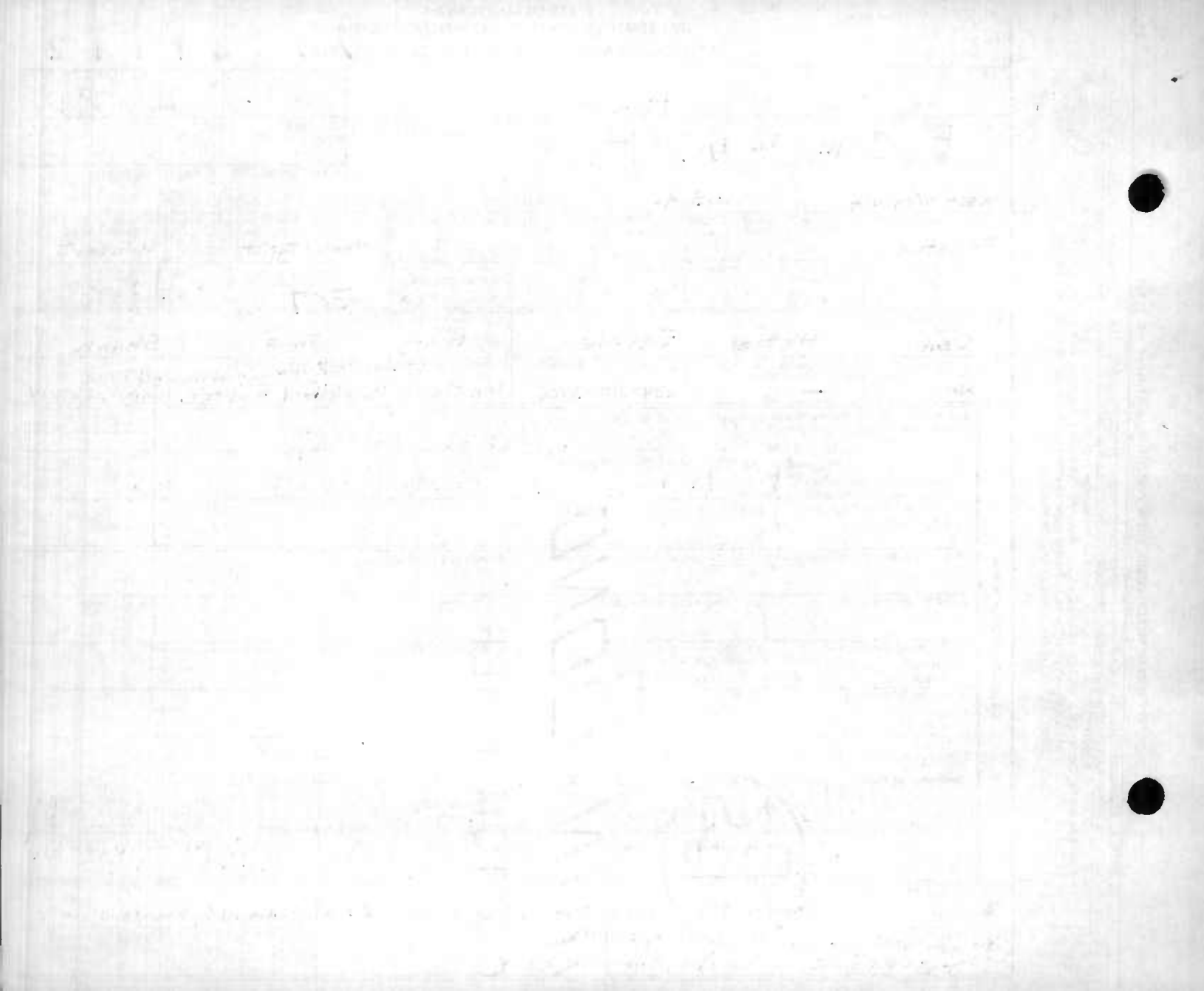
DHMH - 17
(VRA 15 ME (5))
30M 7/73

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE
REGISTRAR

REG. NO. 3 1 1 1 2

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Dorothy Adeline Wolford			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 2 19 79			2b. HOUR 12 27 P M		
3. SEX F	4. RACE Cauc	5. DATE OF BIRTH MONTH DAY YEAR 4 4 27	6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 2 19 79			2d. HOUR 12 27 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Harford MD.		
10. CITY OR TOWN OF DEATH Fallston			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fallston Gen Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk/Typist			12b. KIND OF BUSINESS OR INDUSTRY U.S. Govt.		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 307 Wakefield Place		
13a. STATE Md			13b. CITY OR TOWN Harford			13c. CITY OR TOWN Bel Air					
14. FATHER'S NAME FIRST MIDDLE LAST OSA Hetzel Saville						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jane Shank					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO						16b. SOCIAL SECURITY NO. 734-40-3706			17. INFORMANT (Husband) 638-7116 ADDRESS Mrs. Charles R. Wolford 307 Wakefield Place Bel Air, Maryland 21014		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/40 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Willard P Amoss				TITLE (SPECIFY) M.D. Asst Dir				MEDICAL EXAMINER DATE SIGNED 12/2/79			
EXAMINER'S NAME (TYPE OR PRINT) Willard P Amoss				ADDRESS 2404 Pleasant Hill Rd Fallston, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE DEC. 4, 1979		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION CITY OR TOWN COUNTY STATE Bel Air, Harford Co, Maryland 21014			
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams St. Bel Air, Maryland 21014						25a. DATE REC'D. BY REGISTRAR DEC 4 1979		25b. REGISTRAR'S SIGNATURE Morty McCreedy			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		7 9 3 1 1 1 3		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BEULAH G. WOOD					2a. DATE OF DEATH MONTH DAY YEAR 12 8 79		2b. HOUR 9:11 PM		
3 SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 24 1996		6. AGE (IN YEARS LAST BIRTHDAY) 83		7. IF UNDER 1 YEAR MONTHS DAYS YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TENNESSEE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HARFORD COUNTY MD.			
10 CITY OR TOWN OF DEATH HAVRE DE GRACE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITIZEN'S NURSING HOME				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY HARFORD		13c. CITY OR TOWN BEL AIR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2908 CRESWELL ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST ELI GRAHAM					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE IVESTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 252-72-9310		17. INFORMANT ADDRESS CHART					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease - failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 mos.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonitis</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>4/18/78</u> 19____, to <u>12/8/78</u> 19____, that (I) (we) last saw the deceased alive on <u>12/8/78</u> 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>B.J. Plunkett Jr. M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 12-9-79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B.J. Plunkett, Jr. MD				22e. ADDRESS 617 W. Bel Air Avenue, Aberdeen, Md. 21001					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal/Burial		23b. DATE 10 Dec. 79		23c. NAME OF CEMETERY OR CREMATORY Chattanooga Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Chattanooga Hamilton Tenn.			
24. FUNERAL DIRECTOR NAME Tarring Funeral Home, P.A., Aberdeen, Md. 21001				25a. DATE REC'D. BY REGISTRAR DEC 2 1979		25b. REGISTER'S SIGNATURE			

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7 9 3 1 1 1 4

1. DECEASED-NAME (Type or Print) LENO THOMAS Zane Ha			20. DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 12 15 1979			2b. HOUR 8:30 M											
3. SEX M		4. RACE W		5. DATE OF BIRTH 1-6-95		6. AGE (In years last birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 12 16 1979			2d. HOUR 9:00 M		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD						Md.		
10. CITY OR TOWN OF DEATH Edgewood				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1946 Herwood Rd				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Miner/Retired				12b. KIND OF BUSINESS OR INDUSTRY Coal					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford				13c. CITY OR TOWN Edgewood				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1946 Herwood Rd Edgewood			
14. FATHER'S NAME First Francisco Middle ? Last Zane			15. MOTHER'S MAIDEN NAME First ? Middle UNKNOWN Last ?														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 181-03-4369				17. INFORMANT Sherriff's office				ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY heart Disease 4140 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD - COPD DUE TO, OR AS A CONSEQUENCE OF (c) last Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
22b. DATE SIGNED 12-17-79				22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)													
22d. ACTUAL SIGNATURE Luis E Renjel				22e. EXAMINER'S NAME (Type) LUIS E RENJEL													
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal/Burial				23b. DATE 12/16/79				23c. NAME OF CEMETERY OR CREMATORY All Saints Cemetery				23d. LOCATION (City or Town) (County) (State) Elysburg Northumberland Pa.					
24. FUNERAL DIRECTOR Tarring Funeral Home, P.A., Aberdeen, Md. 21001								25a. REC'D BY REGISTRAR DEC 18 1979				25b. REGISTRAR'S SIGNATURE notary					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMM - 17
(VR A15 ME (5))
30M 7/73

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 31115	
1. DECEASED NAME (TYPE OR PRINT) CARL R. ZANG										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 10 1979	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug. 9 1929		6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna.				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Harford County	
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Harford Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck driver		12b. KIND OF BUSINESS OR INDUSTRY United Parcel	
13a. STATE N.J.				13b. COUNTY Bergen		13c. CITY OR TOWN Garfield		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 484 Palisade Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Carl (mni) Zang				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Loretta Rogers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 176-22-6840		17. INFORMANT ADDRESS Carmela Zang (wife) Same as above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: Multiple injuries IMMEDIATE CAUSE (a) 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:45 PM 12-10-1979		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in truck/fixed object collision.					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION STREET CITY OR TOWN COUNTY STATE I95 mile marker 229, Havre de Grace, Harford Md					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margareta A. Korell				TITLE (SPECIFY) Assistant				DATE SIGNED 12-10-79			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn St.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/14/1979		23c. NAME OF CEMETERY OR CREMATORY St. Nicholas Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Lodi Bergen N.J.			
24. FUNERAL DIRECTOR NAME ADDRESS E. Barnes Fleming Funeral Service -Benson, Md						25a. DATE REC'D. BY REGISTRAR DEC 13 1979		25b. REGISTRAR'S SIGNATURE Pitney Melby			

MEDICAL CERTIFICATION

